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ABSTRACT

This curriculum guide has been constructed in order to bridge the skills gap between licensed practical nursing (LPN) programs and associate degree nursing (ADN) programs in Missouri. The curriculum was developed through a cooperative effort by persons from both sectors. The curriculum contains four major units, each consisting of several lessons, that cover the following topics: (1) the role of the associate degree nurse; (2) communication skills; (3) nursing diagnosis and nursing care plans; and (4) administration of medications. The guide is designed to be used as a formal presentation in a traditional classroom setting or as a self-study guide for individual instruction. Each lesson contains the following components: scope of unit statement, lesson objectives, information assignment, references, introduction, outline, summary and conclusion, interaction questions, classroom/laboratory activities, and evaluation items. A bibliography, a competency certificate, and a competency profile for student evaluation complete the document. (KC)

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Instructor Guide

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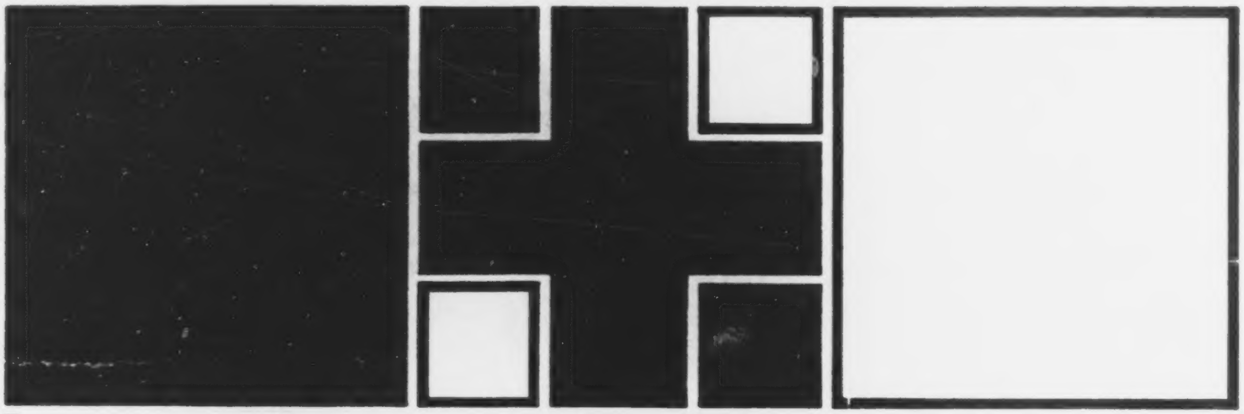

LPN/ADN Bridge Course

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LPN/ADN BRIDGE COURSE

Instructor's Guide

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PREFACE

The LPN/ADN Bridge Course curriculum has been constructed with a consensus of many dedicated individuals from both the practical nurse education sector and the associate degree education sector. The intent of this course is to recognize the existing competencies of the licensed practical nurse by granting credit for Fundamentals of Nursing and preparing them for the transition into an associate degree nursing program. Comparative surveys were conducted of both practical nursing programs and associate degree nursing programs statewide. The survey results are the basis of the content outline which identifies information needed by licensed practical nurses who are entering the associate degree program.

The bridge course curriculum guide was developed from the content outline. It is divided into four major modules/units:

Unit I: The role of the associate degree nurse is discussed. Legal-ethical responsibilities, role transition, and the decision making process are included. Each program is expected to present its own philosophy and conceptual framework in this unit.

Unit II: A review of communication skills is presented in this unit. Client teaching plans, process recordings, and defense mechanisms are included.

Unit III: This unit expands the nursing process by teaching how to develop a nursing diagnosis. Each program will include its own nursing care plan format.

Unit IV: Medication administration is expanded upon in this unit. The legal responsibilities of the registered nurse and medications are included. Special attention is given to the changing role of the LPN to RN.

The lesson plans allow the curriculum guide to be prepared in short, manageable segments. The guide is designed to be utilized as a formal presentation in a traditional classroom setting or as a self-study guide for individual instruction. Each lesson contains the following components:

SCOPE OF UNIT
A teacher-centered statement that includes the goals of the unit; allows the reader to see the comprehensive content of each unit

LESSON OBJECTIVES
A listing of skills the student will be able to accomplish as a result of the lesson; provides the basis for evaluation

INFORMATION ASSIGNMENT
A reading assignment for which the student is responsible

REFERENCE
Resources the instructor uses to support the lesson content

INTRODUCTION

A statement that sets the stage for the learning of the content; tells the student why the lesson is important to him/her

OUTLINE

The content of the lesson; may be informative in nature or it may be the steps of a procedure to learn a skill

SUMMARY AND CONCLUSION

Ties together all the information that was included in the content of the lesson; puts all of the information together in a comprehensive overview; purpose is to reinforce learning by summarizing the major components of the lesson

INTERACTION ITEMS

Questions intended to stimulate and encourage student interaction during the lesson presentation which allow the instructor to build on students' previous learning as well as dispel any misconceptions

CLASSROOM/LABORATORY ACTIVITIES

Activities designed to reinforce learning which allow students to interact with the new information or materials contained in the lesson

EVALUATION ITEMS

An exercise designed to measure the accomplishment of the lesson objectives; may be a written evaluation or skills demonstration

The curriculum becomes individualized when the instructor includes his/her program's philosophy, conceptual framework and nursing care plan format. Individual programs may delete materials presented in other course work. Additional content may be added to increase the scope of a unit if it better serves individual programs.

The dedication with which this course was developed reflects the sincere desire of the nursing community to provide upward mobility within nursing education. This option allows the licensed practical nurse to receive credit for previous learning as he/she pursues further education necessary to practice a higher level of nursing.

LPN/ADN BRIDGE COURSE

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LPN/ADN BRIDGE COURSE INTRUCTIONAL ANALYSIS

DEMONSTRATION	INFORMATION
ROLE OF THE ASSOCIATE DEGREE NURSE	
	1. Philosophy of the ADN program
	2. Nursing theories
	3. Conceptual framework of associate degree nursing
	4. Roles and responsibilities of the ADN
	5. Decision making process
COMMUNICATION	
	6. Nurse-client communication
	7. Kinds of communication
	8. The effects of coping mechanisms on communication
	9. Process recordings
	10. Documentation-recording
	11. Documentation-reporting
	12. Client teaching/learning
NURSING PROCESS	
	13. An overview of the nursing process
	14. Assessment phase
	15. Nursing history
	16. Nursing physical assessment
	17. Nursing diagnosis
	18. Planning phase

DEMONSTRATION	INFORMATION
	19. Implementation phase
	20. Evaluation phase
	21. The nursing care plan
MEDICATION ADMINISTRATION	
	22. Responsibilities of the RN in medication administration
	23. Drug classifications
	24. General principles of medication administration
25. Preparation and administration of oral medications	
26. Preparation and administration of intramuscular injections	
27. Preparation and administration of subcutaneous injections	
28. Preparation and administration of intradermal injections	
	29. Systems of measurement, conversions, and calculations
	30. Drug abuse

LESSON PLAN: 1

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT 1 ROLE OF THE ASSOCIATE DEGREE NURSE

SCOPE OF UNIT:

Nursing is a system of interrelated ideas and actions, and the role of the nurse is interwoven with this system. This unit will explore the philosophy, conceptual framework, role transition from LPN to ADN (RN) and decision making process. The students will utilize this knowledge to understand their school's philosophy, conceptual framework, and the role of the RN.

INFORMATION TOPIC: X OR DEMONSTRATION:

PHILOSOPHY OF THE ADN PROGRAM
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Define philosophy.
2. Identify the six major elements contained in a nursing philosophy.
3. List the six benefits of a nursing philosophy.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. The participating school's philosophy

INFORMATIONAL ASSIGNMENT: (Student)

Kozier, Barbara and Glenora Erb. Fundamentals of Nursing: Concepts and Procedures. 2nd ed. Menlo Park, CA: Addison-Wesley Co., 1983. pp. 4-12.

Wolff, L., et al. Fundamentals of Nursing. 7th ed. New York: J.B. Lippincott Co., 1983. pp. 4-8.

REFERENCES: (Instructor's Additional Information)

Story, Donna K. Career Mobility. St. Louis: C.V. Mosby, 1974.

Chaska, Norma. The Nursing Profession: A Time To Speak. New York: McGraw-Hill, 1983.

Lawrence, Sally. "Curriculum Development: Philosophy, Objectives, and Conceptual Framework." Nursing Outlook, 31 (1983), 160-163.

INTRODUCTION:

This lesson defines and introduces basic facts about a nursing philosophy. The student will compare these facts with the participating school's philosophy. This lesson also introduces the benefits of a philosophy and its impact on the curriculum.

LESSON PLAN: I

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT I ROLE OF THE ASSOCIATE DEGREE NURSE

INFORMATION TOPIC: I-I

OUTLINE: (Key Points)

I. Definition of a Philosophy

   A. Statement of general beliefs, concepts, and attitudes of an individual or group which governs thoughts and conduct

   B. There are no right or wrong views in a philosophy; beliefs belong to group

II. Nursing Philosophy

   A. Refers to the beliefs of the faculty, and how those beliefs will be incorporated into the student curriculum; philosophy is mandated to be student centered

   B. Needed because nursing is a field of diverse facts which must be related to specific nursing actions

   C. Organizes facts into a structured framework for viewing nursing

   D. Composed of elements - not all elements are included in all nursing philosophies; varies with school and faculty

III. Basic Elements of a Nursing Philosophy

   A. Nature of man/woman

      1. May be viewed as holistic being

      2. An open system free from boundaries

      3. A member of a family, a community, a society

      4. A mental, physical, and spiritual being

      5. A unique being; possesses loving intelligence and free will

      6. Capable of self-direction

      7. Has worth and dignity

   B. Description or definition of health

      1. State of dynamic well-being

2. Individual functioning at his/her optimum well-being
3. Ever-changing state based on man's/woman's adaptation to stress
4. State in which man/woman maintains homeostasis
5. State in which man/woman is in harmony with his/her environment
6. State in which man/woman is able to maintain adequate and appropriate response to stress

C. Total view of associate degree nursing

1. Includes skills necessary to make observations and utilitize the nursing process
2. Establishes nursing diagnosis
3. Provides total care for a group of individuals
4. Performs wide range of manipulative skills
5. Cares for clients of all ages
6. Supervises ancillary workers
7. Functions under supervision
8. Has a strong background in scientific principles
9. Exists because ADNs provide vital nursing care

D. Statement on teaching/learning process

1. Occurs in a democratic setting with mutual teacher/student respect
2. Teaching/learning involves cognitive, affective and motor skills
3. Faculty is responsible for building upon student's previous knowledge in a sequential order
4. Faculty guides students through selected learning objectives designed to accomplish specific behaviors
5. Faculty acts as a resource for students
6. Students are responsible for their learning
7. Learning is a continuous process

E. Statement on associate degree nursing education

   1. Belongs in an institution of higher learning; this setting provides a balance between general education and nursing education, with faculty prepared in nursing knowledge and skills

   2. It is a systematized plan for assisting the learner to become competent in a common core of nursing knowledge and skills

   3. Based on learning principles

      a. Familiar to unfamiliar

      b. Simple to complex

      c. General to specific

   4. Includes learning to think critically, to seek out information and to problem solve

F. Role of ADN

   1. An active member of the health team, capable of assessing, planning, implementing, and evaluating nursing care on a daily basis in common health situations

   2. Has strong knowledge of scientific principles necessary for the performance of a wide range of manipulative skills

   3. Capable of meeting individual basic needs in situations involving alterations in homeostasis

   4. Fulfills responsibilities and functions within the limitations defined by the title "Registered Nurse"

IV. Benefits of a Nursing Philosophy

A. Brings faculty together and everyone begins working from the same starting point

B. Students and faculty can interpret school's beliefs to others.

C. Students, by understanding their school's philosophy, can better understand faculty's beliefs and their common views of nursing.

D. Students can select a school whose philosophy is in accordance with his/her own beliefs.

E. Philosophy acts as a guide for selection of other college courses.

   1. Schools with a religious affiliation may require theological courses.

   2. Schools believing in man/woman as a psychosocial being may require courses in psychology and sociology.

F. Philosophy forms the foundation from which the conceptual framework is developed.

V. Summary and Conclusion

A. Definition of a philosophy

B. Nursing philosophy

C. Basic elements of a nursing philosophy

D. Benefits of a nursing philosophy

LESSON PLAN: 1

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT 1 ROLE OF THE ASSOCIATE DEGREE NURSE

INTERACTION ITEMS:

1. Why do schools need a philosophy?
2. How will your program's philosophy help you understand associate degree nursing education?
3. How do you understand your program better since studying its philosophy?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Using a copy of the school's philosophy, identify and discuss the elements.

LESSON PLAN: 1

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT 1 ROLE OF THE ASSOCIATE DEGREE NURSE

EVALUATION ITEMS

1. Define philosophy.

2. The same philosophy may be used for all associate degree nursing schools. True or False? (Circle one.)

3. What are the six basic elements in a philosophy?
   a.
   b.
   c.
   d.
   e.
   f.

4. List the six benefits that a nursing philosophy generally provides.
   a.
   b.
   c.
   d.
   e.
   f.

LESSON PLAN: 1

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT 1 ROLE OF THE ASSOCIATE DEGREE NURSE

ANSWERS TO EVALUATION ITEMS

1. Philosophy is a statement of general beliefs, concepts, and attitudes of an individual or group which governs thoughts and conduct; there are no right or wrong views in a philosophy; beliefs belong to group.

2. False

3. a. Nature of man/woman
   b. Description or definition of health
   c. Total view of associate degree nursing
   d. Statement on teaching/learning process
   e. Statement on associate degree nursing education
   f. Role of ADN

4. a. Brings faculty together and everyone begins working from the same starting point
   b. Students and faculty can interpret school's beliefs to others
   c. Students, by understanding their school's philosophy, can better understand faculty's beliefs and their common views of nursing
   d. Students can select a school whose philosophy is in accordance with his/her own beliefs.
   e. Philosophy acts as a guide for selecting other college courses.
      1. Schools with a religious affiliation may require theological courses.
      2. Schools believing in man/woman as a psychosocial being may require courses in psychology and sociology
   f. Philosophy forms foundation from which the conceptual framework is developed.

LESSON PLAN: 2

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT I ROLE OF THE ASSOCIATE DEGREE NURSE

SCOPE OF UNIT:

Nursing is a system of interrelated ideas and actions, and the role of the nurse is interwoven with this system. This unit will explore the philosophy, conceptual framework, role transition from LPN to ADN (RN) and decision making process. The students will utilize this knowledge to understand their school's philosophy, conceptual framework, and the role of the RN.

INFORMATION TOPIC: X OR DEMONSTRATION:

NURSING THEORIES
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Define the following terms:
    a. Theory
    b. Nursing theory
2. Explain why a school needs a nursing theory model.
3. List five purposes of a nursing theory.
4. Compare and contrast Orem's theory model and Roy's theory model according to these points:
    a. Goal of nursing
    b. View of man/woman
    c. Definition of nursing
    d. View of the nursing process

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Supplementary materials on participating school's theory. (They may have an original theory.)

INFORMATIONAL ASSIGNMENT: (Student)

Kozier, Barbara and Glenora Erb. Fundamentals of Nursing: Concepts and Procedures. 2nd ed. Menlo Park, CA: Addison-Wesley Co., 1983. pp. 7-11.

Wolff, L., et al. Fundamentals of Nursing. 7th ed. New York: J.B. Lippincott Co., 1983. pp. 17-24.

REFERENCES: (Instructor's Additional Information)

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Flaskerund, Jacquelyn. "Utilizing a Nursing Conceptual Model in Basic Level Curriculum Development." Journal of Nursing Education, 22 (1983), 224-227.

Orem, Dorothea. Nursing Concepts of Practice. New York: McGraw-Hill, 1984.

Randell, B., et al. Adaptation Nursing. St. Louis: C.V. Mosby, 1982.

Roy, Sr. Callista. Introduction to Nursing: An Adaptation Model. Englewood Cliffs: Prentice Hall, 1978.

Story, Donna K. Career Mobility. St. Louis: C.V. Mosby, 1974.

INTRODUCTION:

A school of nursing patterns its philosophy, conceptual framework, and curriculum from a nursing theory model. It may be a known nursing model or it may be unique. A nursing theory attempts to describe or explain nursing. Nursing theories are used by faculty to guide their students through the general body of knowledge called "nursing knowledge." Nursing theories are logical and consistent with other validated theories and laws. This lesson introduces you to two known theoretical nursing models and your school's model. There are over a dozen nurse authors with recognized nursing theory models. Your school may be using one of these models or may have an eclectic model of its own. Whatever model, it will attempt to explain nursing and the beliefs about nursing that your faculty holds.

LESSON PLAN: 2

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT I ROLE OF THE ASSOCIATE DEGREE NURSE

INFORMATION TOPIC: I-2

OUTLINE: (Key Points)

I. Definitions

   A. Theory - a systematically related set of statements that explains observed facts and predicts part of the real world

   B. Nursing theory

      1. Set of interrelated concepts or beliefs that attempts to explain the phenomenon called nursing

      2. An approach to practicing nursing based on theory

      3. How nursing views man/woman and interfaces with him/her as he/she experiences wellness or illness

II. Purposes of a Nursing Theory

   A. Provides a structured, systematic way of examining and carrying out nursing practice

   B. Primary force to elevate nursing from a skill related job to a bona fide profession

   C. Provides the framework to integrate knowledge from the psychological and biological aspects of man/woman

   D. Provides a systematic way of viewing reality

   E. Guides research and provides a framework for evaluating methods of practice

III. Examples of Nursing Theory Models

   A. Dorothea Orem's self-care theory model

      1. Goal of nursing - achievement of optimal client self-care so the client can achieve and maintain an optimal health status

      2. View of man/woman - man/woman is unique and an integrated whole; inability to maintain self-care denotes a deficit

      3. Definition of nursing

a. Nursing is a helping service. It is a personal, family, and community service within the health field.

b. The focus of nursing is to help the individual overcome health care deficits.

4. View of nursing process - nursing is an interpersonal process with deliberate action using a three-step nursing process

   a. Nursing diagnosis

   b. Planning

   c. Actions of nurse

5. Key terminology

   a. Self-care deficit

   b. Self-care requirements

   c. Demands

B. Sr. Callista Roy's adaptation model*

1. Goal of nursing - to bring about an adaptive state in the four adaptive modes

2. View of man

   a. Man is a biopsychosocial being and has four modes of adaptation

      (1) Physiological needs

      (2) Self-concept

      (3) Role function

      (4) Interdependence

   b. Adaptation of man/woman is a response to an external or internal stimuli

3. Definition of nursing - nursing is a scientific discipline and is practice oriented. "Nursing is concerned with man as a total being at some point along the health-illness continuum." (Roy, 1974)

4. View of the nursing process - the nursing process is a problem-solving process with six steps

   a. Assessment

***NOTE:** This theory uses "man" as global term for "person."

            - b. Problem identification
            - c. Goal setting
            - d. Intervention
            - e. Selection of approaches
            - f. Evaluation
        - 5. Key terminology
            - a. Adaptation
            - b. Stimuli
            - c. Stressors
            - d. Modes of adaptation
    - C. Your school's nursing theory model

        INSTRUCTOR NOTE: This section will require the participating school's theoretical nursing model. Please identify the following:

        - 1. Goals of nursing
        - 2. View of man/woman
        - 3. Definition of nursing
        - 4. View of the nursing process
        - 5. Key terminology

- IV. Summary and Conclusion
    - A. Definitions
    - B. Purposes of a nursing theory
    - C. Examples of nursing theory models

LESSON PLAN: 2

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT I ROLE OF THE ASSOCIATE DEGREE NURSE

INTERACTION ITEMS:

1. How does your school's nursing theory model compare with the other theory models with regard to:
   a. Goals of nursing
   b. View of man/woman
   c. Definition of nursing
   d. View of the nursing process

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

LESSON PLAN: 2

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT I ROLE OF THE ASSOCIATE DEGREE NURSE

EVALUATION ITEMS

1. Define the following terms:
   - a. Theory
   - b. Nursing theory
2. Explain why a school needs a nursing theory model.
3. List five purposes of a nursing theory.
   - a.
   - b.
   - c.
   - d.
   - e.
4. Compare and contrast Orem's theory model and Roy's theory model according to these points:
   - a. Goal of nursing

b. View of man/woman

c. Definition of nursing

d. View of the nursing process

LESSON PLAN: 2

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT I ROLE OF THE ASSOCIATE DEGREE NURSE

ANSWERS TO EVALUATION ITEMS

1. a. Theory - a systematically related set of statements that explains observed facts and predicts part of the real world
   b. Nursing theory
      1. Set of interrelated concepts or beliefs that attempts to explain the phenomenon called nursing
      2. An approach to practicing nursing based on theory
      3. How nursing views man/woman and interfaces with him/her as he/she experiences wellness or illness

2. A school needs a nursing theory model to explain how that particular school views nursing and defines its practice.

3. a. Provides a structured, systematic way of examining and carrying out nursing practice.
   b. Primary force to elevate nursing from a skill related job to a bona fide profession
   c. Provides the framework to integrate knowledge from the psychological and biological aspects of man/woman
   d. Provides a systematic way of viewing reality
   e. Guides research and provides a framework for evaluating methods of practice

4. a. Orem states that the goal of nursing is achievement of optimal client self-care so the client can achieve and maintain an optimal health status, whereas Roy defines the goal of nursing as bringing about an adaptive state in the four modes of adaptation.
   b. Orem views man/woman as unique, and an integrated whole. She also notes that inability to maintain self-care denotes a deficit. Roy's view is that of man as a biopsychosocial being who has four modes of adaptation, i.e., physiological needs, self concept, role function, interdependence.
   c. Orem defines nursing as a helping service--a personal, family, and community service within the health field. Roy's definition of nursing states that nursing is a practice oriented, scientific discipline..."Nursing is concerned with man as a total being at some point along the health-illness continuum." (Roy, 1974)
   d. Orem's view of the nursing process states that nursing is an interpersonal process with deliberative action using a three-step nursing process of nursing diagnosis, planning, and actions of the nurse. Roy sees the nursing process as a problem solving process with six steps: Assessment; problem identification; goal setting; intervention; selection of approaches; and evaluation.

LESSON PLAN: 3

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT I ROLE OF THE ASSOCIATE DEGREE NURSE

SCOPE OF UNIT:

Nursing is a system of interrelated ideas and actions, and the role of the nurse is interwoven with this system. This unit will explore the philosophy, conceptual framework, role transition from LPN to ADN (RN) and decision making process. The students will utilize this knowledge to understand their school's philosophy, conceptual framework, and the role of the RN.

INFORMATION TOPIC: X OR DEMONSTRATION:

CONCEPTUAL FRAMEWORK OF ASSOCIATE DEGREE NURSING
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Define the following terms:
    a. Conceptual framework
    b. Threads
2. List the four major threads usually found in a nursing conceptual framework.
3. Explain how a professional nursing school uses the conceptual framework in the curriculum.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. The participating school's conceptual framework and philosophy

INFORMATIONAL ASSIGNMENT: (Student)

Kozier, Barbara and Glenora Erb. Fundamentals of Nursing: Concepts and Procedures. 2nd ed. Menlo Park, CA: Addison-Wesley Co., 1983. pp. 4-8.

Wolff, L., et al. Fundamentals of Nursing. 7th ed. New York: J.B. Lippincott Co., 1983. pp. 16-18.

REFERENCES: (Instructor's Additional Information)

Chaska, Norma. The Nursing Profession: A Time To Speak. New York: McGraw-Hill, 1983.

Lawrence, Sally and Rena Lawrence. "Philosophy, Objectives, and Conceptual Framework." Nursing Outlook, 31 (1983), 160-163.

McCann/Flynn, Janet-Beth, and Phyllis Burroughs Heffron. Nursing From Concept to Practice. Bowie, MD: Robert J. Brady Co., 1984.

Story, Donna K. Career Mobility. St. Louis: C.V. Mosby, 1974.

INTRODUCTION:

This lesson explains the conceptual framework in nursing. A framework helps to structure and form the basic ideas in a nursing model. Nursing theory beliefs are defined and elaborated throughout the conceptual framework. The conceptual framework is the systematic ordering of these beliefs that gives structure and direction to the practice of nursing. These beliefs may be called "threads" and are planned throughout the curriculum. This lesson includes a definition and examples of threads utilized in a conceptual framework.

LESSON PLAN: 3

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT I ROLE OF THE ASSOCIATE DEGREE NURSE

INFORMATION TOPIC: I-3

OUTLINE: (Key Points)

I. Definitions

   A. Conceptual framework

      1. Defined as systematic ordering of concepts or ideas basic to nursing, cast in a meaningful relationship

      2. Gives structure and direction to the practice of nursing

      3. Curriculum decisions are based upon the conceptual framework.

   B. Threads

      1. Defined as beliefs or concepts defined through a school's nursing model upon which the curriculum is planned

      2. Act as guides to faculty and students to relate theory to practice

         a. System for classifying

            (1) Knowledge

            (2) Skills

            (3) Values

         b. Organizes facts into a system by unit of function

         c. This process of utilization is the action phase of the conceptual framework; permeates the school's philosophy and objectives for each class.

II. Threads Commonly Included in Structural Frameworks

   A. Individual/Man/Woman

      1. May be defined as an entirety or whole as well as a particular aspect of an individual (such as a client); example: Roy's nursing model explains persons in their entirety as adaptive, biopsychosocial beings

      2. The nursing theory model your school chooses will guide faculty in

developing communication, behavior and interpersonal aspects of the curriculum

B. Society/Environment

1. Defined as changing and in constant interaction with the individual; person's ability to respond to his/her environment is generally considered to be a determinant of health or illness; example: D. Johnson's theory states environment is both external and internal and creates behavioral responses

2. Other models may define environment as both a physical and social influence on system's needs; influences may be positive or negative.

3. Environment includes family, community, nation, and universe; specific meanings a particular school's nursing model places on these factors will influence the curriculum.

C. Health: Illness/Wellness

1. An essential part of any nursing model as it exists within the dimension of the person's life where nursing intervention occurs

2. Health may be conceptualized as:

   a. A positive response to the environmental stimuli (Roy, 1980)

   b. Self-care (Orem 1971, 1980)

3. Your school's view of health and its integration into your curriculum will depend on your school's nursing model's definition of the health concept.

D. Nursing process

1. Defined as activity or intervention that nurse performs; allows nurse to give care in a structured and decisive manner

2. Consists of:

   a. Assessment

   b. Nursing diagnosis

   c. Planning

   d. Intervention

   e. Evaluation

3. Role and function are inherent to nursing process

III. Summary and Conclusion

A. Definitions

B. Threads commonly included in structural frameworks

LESSON PLAN: 3

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT I ROLE OF THE ASSOCIATE DEGREE NURSE

INTERACTION ITEMS:

1. What are the "threads" in your school's conceptual framework?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Discuss the major concepts found in the conceptual framework and philosophy.

LESSON PLAN: 3

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT I ROLE OF THE ASSOCIATE DEGREE NURSE

EVALUATION ITEMS

1. Define the following terms:
   a. Conceptual framework

   b. Threads

2. List the four major threads usually included in a conceptual framework.
   a.
   b.
   c.
   d.

3. Explain how a professional nursing school uses the conceptual framework in the curriculum.

LESSON PLAN: 3

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT I ROLE OF THE ASSOCIATE DEGREE NURSE

ANSWERS TO EVALUATION ITEMS

1. a. Conceptual framework - a systematic ordering of concepts or ideas basic to nursing, cast in a meaningful relationship
   b. Threads - beliefs or concepts defined through a school's nursing model upon which the curriculum is planned

2. a. Individual/Man/Woman
   b. Society/Environment
   c. Health: Illness/Wellness
   d. Nursing Process

3. The conceptual framework defines the four major threads (i.e., Individual/Man/Woman; Society/Environment; Health; Nursing Process) as to their nursing model. These definitions are utilized throughout the curriculum, and guide the faculty in their relation of theory to practice.

LESSON PLAN: 4

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT I ROLE OF THE ASSOCIATE DEGREE NURSE

SCOPE OF UNIT:

Nursing is a system of interrelated ideas and actions, and the role of the nurse is interwoven with this system. This unit will explore the philosophy, conceptual framework, role transition from LPN to ADN (RN) and decision making process. The student will utilize this knowledge to understand their school's philosophy, conceptual framework, and the role of the RN.

INFORMATION TOPIC: X OR DEMONSTRATION:

ROLES AND RESPONSIBILITIES OF THE ADN
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Define role.
2. List the five major roles of the ADN.
3. Compare LPN and ADN roles utilizing the five major roles of the ADN.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. TM I: Roles of the Associate Degree Nurse
2. Nurse Practice Act
3. ADN competencies: NLN Task Force: NLN 14-1905

INFORMATIONAL ASSIGNMENT: (Student)

Kozier, Barbara and Glenora Erb. Fundamentals of Nursing: Concepts and Procedures. 2nd ed. Menlo Park, CA: Addison-Wesley Co., 1983. pp. 21-32.

Wolff, L., et al. Fundamentals of Nursing. 7th ed. New York: J.B. Lippincott Co., 1983. pp. 29-34.

REFERENCES: (Instructor's Additional Information)

Chaska, Norma. The Nursing Profession: A Time To Speak. New York: McGraw-Hill, 1983.

NLN publication: "Competencies of the Associate Degree Nurse on Entry Into Practice." 1978.

NLN publication: "Practical Nursing Curriculum and Competencies." 1980. (#38-1820)

Story, Donna K. Career Mobility. St. Louis: C.V. Mosby, 1974.

INTRODUCTION:

The LPN's role is different than that of the ADN even though some functions overlap. There is a certain body of knowledge that is fundamental to all nurses. The main differences are in the area of accountability, responsibility, evaluation, and management. This lesson explains these areas.

LESSON PLAN: 4

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT I ROLE OF THE ASSOCIATE DEGREE NURSE

INFORMATION TOPIC: I-4

OUTLINE: (Key Points)

I. Definitions

  A. Role - a behavior response involving other human beings

  B. Socialization - the process of learning roles occurring through:

    1. Intentional learning - in-depth, formalized education

    2. Incidental learning - personal contacts that involve attitudes and beliefs

II. Differences Between LPN and ADN Roles - major differences related to intentional and incidental learning

  A. The ADN integrates more science courses into nursing knowledge.

  B. The ADN utilizes a more complex body of knowledge in nursing interactions.

  C. The ADN has a more in-depth understanding of anatomy and physiology and the potential for patient complications.

  D. The ADN utilizes additional general education courses to enhance knowledge.

  E. Associate degree nursing programs are usually two years in duration, whereas most practical nursing programs are one year.

III. Five Major Roles of the ADN (TM 1)

  A. Provider of care role

    1. ADN's role

      a. Uses nursing process to formulate and maintain individualized nursing care plans; evaluates plan and makes necessary changes

      b. Maintains individuality of the client; includes client's family in caring/healing process

    c. Provides follow-up care to clients undergoing tests and therapeutic procedures
    d. Utilizes nursing knowledge and skills to provide client care to maintain integrity or restore function
    e. Maintains a general environment conducive to a positive therapeutic regime
    f. Implements a care plan with short and long-term goals
    g. Administers medications
    h. Develops nursing diagnosis and plans interventions

2. LPN's role
    a. Provides care to a select group of clients under the supervision of RN
    b. Utilizes technical skills to give client care
    c. Develops basic nursing care plans
    d. Contributes to the development of more comprehensive nursing care plans
    e. Administers those medications which are approved for LPN administration

3. Differences in Roles
    a. LPN practices under the supervision of an RN who is responsible for evaluating the plan of care.
    b. RN has a "global" responsibility for the care of clients; coordinates care for both short and long-term goals.

B. Communication role

1. ADN's role
    a. Assesses nonverbal and verbal communication behavior of clients and families based upon knowledge and techniques of interpersonal communication
    b. Uses communication skills as a method for data collection and integrates this knowledge into interventions and evaluation of care

    c. Evaluates the effectiveness of one's own communication skills with clients, coworkers, family, and others

2. LPN's role

    a. Recognizes the importance of effective communication

    b. Recognizes ineffective communication and reports to RN

    c. Utilizes basic communication techniques with clients and health team

3. Differences in roles

    a. LPN assists the RN in the development of an alternative approach to communication.

    b. RN recognizes, assesses, and evaluates communication to clients and family; if communication is ineffective, RN must choose another approach for therapeutic communication.

C. Client teacher role

1. ADN's role

    a. Assesses client situations which need information or support to maintain health

    b. Develops short-range teaching plans for clients based on short and long-range goals

    c. Implements teaching plans at the client's level of knowledge

    d. Evaluates the effectiveness of client's learning and then restructures teaching plan if needed

2. LPN's role

    a. Identifies overt learning needs of clients

    b. Assists in the implementation of established nursing care plans

    c. Directs individuals and families to appropriate person for health teaching and community resources

3. Differences in roles

    a. LPN role in client teaching is usually more limited than that of the RN.

- b. Teaching by the ADN includes more in-depth and complex teaching over more varied areas.

D. Manager of client care role

- 1. ADN's role
    - a. Manages a group of clients with common, well-defined health problems in structured settings
    - b. Assesses and sets nursing priorities
    - c. Assists other nursing personnel to develop skills in giving care
    - d. Plans and/or provides client care utilizing other personnel to their best abilities, educational preparation, and experience
- 2. LPN's role
    - a. Manages own actions in planning and organizing client care
    - b. Utilizes physical and behavioral science knowledge to make practical nurse decisions
    - c. Reports significant observations of the client to the RN
- 3. Differences in roles
    - a. LPN is responsible for management of his/her own clients.
    - b. ADN also manages his/her own clients but may have the responsibility of assessing and guiding others on the health team in their care delivery.
    - c. ADN utilizes other personnel on the health team to their educational abilities.

E. Member of the health professions role

- 1. ADN's role
    - a. Accountable for his/her actions within the nursing professional practice
    - b. Practices his/her profession within the ethical and legal framework of the profession
    - c. Assumes responsibility for continued learning and self-development
    - d. Consults with more experienced nurse when a nursing problem is beyond his/her scope of practice

e. Works within the policies of the institution in which employed

f. Shows respect for the dignity of his/her clients

g. Shows self-direction

2. LPN's role

   a. Accepts individual responsibility and accountability for his/her LPN nursing practice

   b. Practices within the professional, ethical, and legal framework for LPNs

   c. Assumes responsibility for continued learning and self-development

   d. Works within the policies of the institution in which employed

   e. Shows respect for the dignity of his/her clients

3. Differences in roles

   a. LPN is mainly accountable for his/her own actions and practicing within the scope of LPN nursing.

   b. ADN is also accountable for his/her own activities and practicing within his/her scope of duties.

   c. ADN must be self-directed.

   d. Both are valuable members of the health team.

IV. Summary and Conclusion

   A. Definitions

   B. Differences between LPN and ADN roles

   C. Five major roles of the ADN

LESSON PLAN: 4

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT I ROLE OF THE ASSOCIATE DEGREE NURSE

INTERACTION ITEMS:

1. What are the differences in roles and responsibilities of the RNs with whom you have worked?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

LESSON PLAN: 4

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT I ROLE OF THE ASSOCIATE DEGREE NURSE

EVALUATION ITEMS

1. Define role.

2. List the five major roles of the ADN.

   a.

   b.

   c.

   d.

   e.

3. Compare LPN and ADN roles by describing one major difference for each of the five major ADN roles.

LESSON PLAN: 4

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT I ROLE OF THE ASSOCIATE DEGREE NURSE

ANSWERS TO EVALUATION ITEMS

1. Role - a behavior response involving other human beings

2. a. Provider of care role
   b. Communication role
   c. Client teacher role
   d. Manager of client care role
   e. Member of the health profession role

3. a. Provider of care role - any one of the following:
      (1) LPN practices under the supervision of an RN who is responsible for evaluating the plan of care
      (2) RN has a "global" responsibility for the care of clients; coordinates care for both short and long-term goals.
   b. Communication role - any one of the following:
      (1) LPN assists RN in the development of an alternative approach to communication
      (2) RN recognizes, assesses, and evaluates communication to patients and family; if communication is ineffective, RN must choose another approach for therapeutic communication
   c. Client teacher role - any one of the following:
      (1) LPN role in client teaching is usually more limited than that of the RN.
      (2) Teaching by the ADN includes more in-depth and complex teaching over more varied areas.
   d. Manager of client care role - any one of the following:
      (1) LPN is responsible for management of his/her own clients
      (2) ADN also manages his/her own clients but may have the responsibility of assessing and guiding others on the health team in their care delivery.
      (3) ADN utilizes other personnel on the health team to their educational abilities.
   e. Member of the health professions role - any one of the following:
      (1) LPN is mainly accountable for his/her own actions and practicing within the scope of LPN nursing.
      (2) ADN is also accountable for his/her own activities and practicing within his/her scope of duties.
      (3) ADN must be self-directed.
      (4) Both are valuable members of the health team.

Roles of the Associate Degree Nurse

Provider of care

Communicator

Client Teacher

Manager of
Client Care

Member of the
Health Professions

LESSON PLAN: 5

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT I ROLE OF THE ASSOCIATE DEGREE NURSE

SCOPE OF UNIT:

Nursing is a system of interrelated ideas and actions, and the role of the nurse is interwoven with this system. This unit will explore the philosophy, conceptual framework, role, transition from LPN to ADN (RN) and decision making process. The student will utilize this knowledge to understand his/her school's philosophy, conceptual framework, and the role of the RN.

INFORMATION TOPIC: X OR DEMONSTRATION:

DECISION MAKING PROCESS
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Define decision making process.
2. State the five steps in a decision making process.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

INFORMATIONAL ASSIGNMENT: (Student)

Kozier, B. and G. Erb. Fundamentals of Nursing: Concepts and Procedures. 2nd ed. Menlo Park, CA: Addison-Wesley Co., 1983. pp. 417-423.

Wolff, L., et al. Fundamentals of Nursing. 7th ed. New York: J.B. Lippincott Co., 1983. pp. 254-268.

REFERENCES: (Instructor's Additional Information)

Watzlawick, Paul, et al. Change. New York: W.W. Norton Co., 1974.

INTRODUCTION:

Decision making involves change. Change can evolve in a structured manner. Good decisions are made when the processing is logical. A decision making process becomes imperative at the RN level. The role change from LPN to ADN mandates a working knowledge of this process. This lesson will give the student an introduction to a decision making process that can be utilized for personal as well as professional decisions.

LESSON PLAN: 5

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT I ROLE OF THE ASSOCIATE DEGREE NURSE

INFORMATION TOPIC: I-6

OUTLINE: (Key Points)

I. Definition of the Decision Making Process - a systematic method which is utilized to arrive at a logical conclusion; used to make personal decisions as well as client decisions

II. Steps in the Decision Making Process

A. Determine that a problem exists, and that a decision needs to be made.

EXAMPLE: A high blood pressure is reported to you.

B. Gather data to clarify what decision(s) need to be made.

EXAMPLE: Assess the client to determine the extent of the problem.

C. Determine and analyze alternate decisions to be made.

EXAMPLE: The client may need:

1. Physician to be notified
2. Medication
3. Supportive nursing measures
4. Nothing

D. Select a course of action.

EXAMPLE: Act on decision made in II, C.

E. Evaluate the effect of your decision.

EXAMPLE: Did the client's condition improve?

III. Summary and Conclusion

A. Definition of the decision making process

B. Steps in the decision making process

LESSON PLAN: 5

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT I ROLE OF THE ASSOCIATE DEGREE NURSE

INTERACTION ITEMS:

1. How are the methods you currently use to make decisions and the decision making process presented in this lesson similiar? How are they different?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. In an appropriate clinical setting, have students observe how decisions are made.
2. In a clinical setting have students observe who makes the decisions, and if possible, what processing took place.

LESSON PLAN: 5

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT I ROLE OF THE ASSOCIATE DEGREE NURSE

EVALUATION ITEMS

1. Define decision making process.

2. State the five steps included in a decision making process.
   - a.
   - b.
   - c.
   - d.
   - e.

LESSON PLAN: 5

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT I ROLE OF THE ASSOCIATE DEGREE NURSE

ANSWERS TO EVALUATION ITEMS

1. Decision making process - a systematic method which is utilized to arrive at a logical conclusion; used to make personal decisions as well as client decisions

2. a. Determine that a problem exists, and that a decision needs to be made.
   b. Gather data to clarify what decision(s) need to be made.
   c. Determine and analyze alternate decisions to be made.
   d. Select a course of action
   e. Evaluate the effect of your decision

LESSON PLAN: I

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATION

SCOPE OF UNIT:

This unit is designed to teach the student essential facts about the communication process and effective and ineffective methods of communicating with clients and with other members of the health care team. The teaching/learning process will be included to guide the student's development of a client teaching plan. Process recordings will be used to assess and evaluate student-client interactions. The unit will help the student develop a beginning understanding of the documentation process on the professional level in relation to client records.

INFORMATION TOPIC: X OR DEMONSTRATION:

NURSE - CLIENT COMMUNICTION

(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match the following terms with the appropriate definitions:
    a. Communication
    b. Receiver
    c. Sender
    d. Message
    e. Response
    f. Communication process
2. Identify and describe three factors which influence the communication process.
3. Identify the purpose of communication in the nurse-client relationship.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. TM I: Components of the Communication Process

INFORMATIONAL ASSIGNMENT: (Student)

Kozier, B. and G. Erb. Fundamentals of Nursing: Concepts and Procedures. 2nd ed. Menlo Park, CA: Addison-Wesley Co., 1983. pp. 359-388.

Wolff, L., et al. Fundamentals of Nursing. 7th ed. New York: J.B. Lippincott Co., 1983. pp. 224-235.

REFERENCES: (Instructor's Additional Information)

Kemp, Brenda and Adele Pillitteri. Fundamentals of Nursing. Boston: Little, Brown & Co., 1984.

Sorensen, Karen and Joan Luckmann. Basic Nursing. Philadelphia: W.B. Saunders Co., 1979.

Sundeen, et al. Nurse-Client Interaction. St. Louis: C.V. Mosby Co., 1976.

Wilson, Holly S. and Kneisl. Psychiatric Nursing. 2nd ed. Menlo Park, CA: Addison-Wesley Co., 1983.

INTRODUCTION:

This lesson introduces essential facts about communication and the communication process.

LESSON PLAN: I

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATION

INFORMATION TOPIC: II-I

OUTLINE: (Key Points)

I. The Communication Process and Its Components

- A. Communication process - interaction of all of the components of communication; considered a process because when communication occurs, the components of the activity and the activity itself are dynamic, continually changing
- B. Components of the communication process
    - 1. Communication - act of sharing information (message and response) between sender and receiver
    - 2. Message - what is said or written
    - 3. Sender - person wanting to convey message; source-encoder
    - 4. Receiver - listener; decoder
    - 5. Response - message receiver returns to sender; feedback

II. Factors Which Influence the Communication Process

- A. Perception - varies with personality traits, values, life experiences
- B. Personal values - based on moral and ethical principles
- C. Culture - varies with culturally transmitted behaviors and beliefs
- D. Ability of sender - to speak, hear, see, comprehend stimuli
- E. Personal space - distance person prefers to maintain when interacting with others (intimate, personal, social, public exchanges)
- F. Role, relationship, and purpose between sender and receiver - example: role of nurse in relationship with doctor discussing client care
- G. Time - preceding or following interaction
- H. Setting or environment - location and/or environment of interaction (privacy, temperature of room, etc.)

I. Attitudes - beliefs, thoughts, feelings about people and events (caring, respect, acceptance, etc.)

J. Emotions - joy, sorrow, anger, etc.

K. Level of self-esteem

1. People with high self-esteem communicate honestly and with confidence

2. People with low self-esteem give double messages

III. Purposes of Communication

A. To gather information

B. To validate information

C. To share information, ideas, feelings

D. To develop rapport/relationship

IV. Summary and Conclusion

A. The communication process and its components

B. Factors which influence the communication process

C. Purposes of communication

LESSON PLAN: I

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATION

INTERACTION ITEMS:

1. How can each factor which influences communication change the meaning of messages?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Sit back-to-back with puzzles that are identical, except for the color of the pieces. Sender describes how to put puzzle together by color and shape of pieces. Receiver can't follow directions because his/her colored pieces are different. Come back together as a group to discuss feelings resulting from unsuccessful communication.
2. Describe the four basic components of the communication process.

LESSON PLAN: I

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATION

EVALUATION ITEMS

Match terms and definitions

1. ______ Communication
2. ______ Receiver
3. ______ Message
4. ______ Sender
5. ______ Response
6. ______ Communication process

a. What is said
b. Decoder
c. Feedback
d. Process of sharing information
e. Encoder
f. Dynamic, continually changing

7. Write a brief description of three factors which influence the communication process.

   a. Perception

   b. Personal space

   c. Attitudes

8. One purpose of communication between a nurse and a client is:

LESSON PLAN: 1

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATION

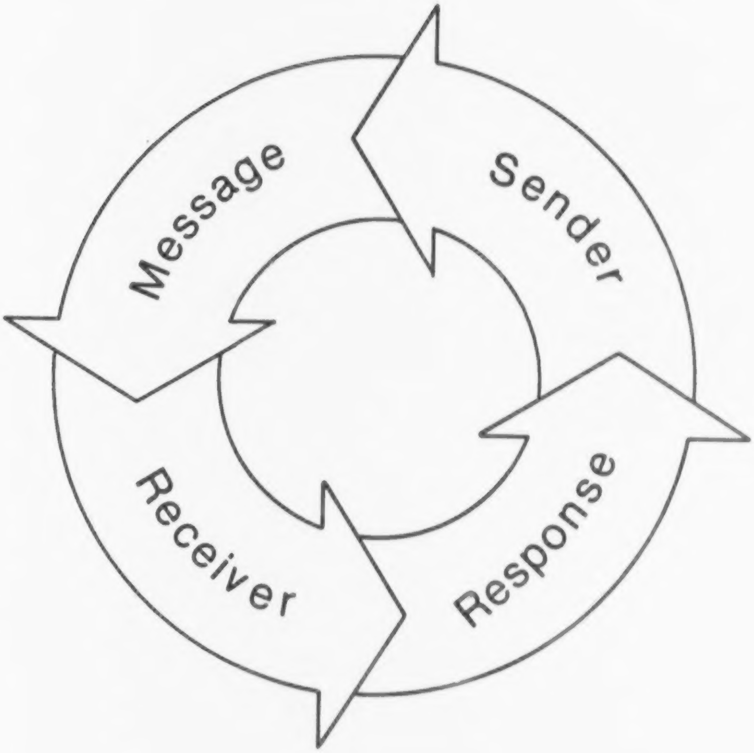
ANSWERS TO EVALUATION ITEMS

1. d
2. b
3. a
4. e
5. c
6. f

7.
   a. Perception - varies with personality traits, values, life experiences
   b. Personal space - distance person prefers to maintain when interacting with others (intimate, personal, social, public exchanges)
   c. Attitudes - beliefs, thoughts, feelings about people and events (caring respect, acceptance, etc.)

8. Purpose of communication - one of the following:
   a. To gather information
   b. To validate information
   c. To share information, ideas, feelings
   d. To develop rapport/relationship

Components of the Communication Process


Sender
Response
Receiver
Message

LESSON PLAN: 2

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATION

SCOPE OF UNIT:

This unit is designed to teach the student essential facts about the communication process and effective and ineffective methods of communicating with clients and with other members of the health care team. The teaching/learning process will be included to guide the student's development of a client teaching plan. Process recordings will be used to assess and evaluate student-client interactions. The unit will help the student develop a beginning understanding of the documentation process on the professional level in relation to client records.

INFORMATION TOPIC: X OR DEMONSTRATION:

KINDS OF COMMUNICATION
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Define verbal and nonverbal communication.
2. Identify at least five characteristics of effective verbal communication.
3. Identify at least five barriers to effective verbal communication.
4. Identify ways in which nonverbal messages are communicated.
5. Identify skills necessary for the nurse to assess nonverbal behavior.
6. Identify at least three of a nurse's own nonverbal communication patterns.
7. Describe three aspects of the systematic approach to assessing nonverbal behavior.
8. Explain the limitations of nonverbal communication.
9. Differentiate between therapeutic and nontherapeutic communication.
10. Identify and describe therapeutic techniques that promote effective communication.

11. Define rapport.

12. Identify and discuss three phases of the nurse-client relationship.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO1: Communication
2. Trainex 292 - The Receiving Process
3. Trainex 293 - Effective Listening
4. Trainex 294 - Verbal Barriers to Communication
5. Trainex 295 - Nonverbal Barriers to Communication

INFORMATIONAL ASSIGNMENT: (Student)

Kozier, B. and G. Erb. Fundamentals of Nursing: Concepts and Procedures. 2nd ed. Menlo Park, CA: Addison-Wesley Co., 1983. pp. 359-388.

Peterson, Margaret H. "Understanding Defense Machanisms". American Journal of Nursing, 72, No. 9 (1972), 1651 - 1674.

Wolff, L., et al. Fundamentals of Nursing. 7th ed. New York: J.B. Lippincott Co., 1983. pp. 224-235.

REFERENCES: (Instructor's Additional Information)

Kemp, Brenda and Adele Pillitteri. Fundamentals of Nursing. Boston: Little, Brown & Co., 1984.

Sorensen, Karen and Joan Luckmann. Basic Nursing. Philadelphia: W.B. Saunders Co., 1979.

Sundeen, et al. Nurse-Client Interaction. St. Louis: C.V. Mosby Co., 1976.

Wilson, Holly S. and Kneisl. Psychiatric Nursing. 2nd ed. Menlo Park, CA: Addison-Wesley Co., 1983.

INTRODUCTION:

This lesson concerns effective verbal and nonverbal communication and some of the barriers and limitations encountered. Therapeutic and nontherapeutic techniques involved in the nurse-client relationship will be discussed.

LESSON PLAN: 2

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATIONS

INFORMATION TOPIC: II-2

OUTLINE: (Key Points)

I. Verbal Communication

  A. Definition - Conscious effort in choosing words; words vary according to culture, socioeconomic background, age, and education; either written or oral.

  B. Characteristics of effective verbal communication

    1. Simplicity in choice of words - understandable and not overstated
    2. Clarity in presentation - noncomplex
    3. Timing and relevance - sensitivity to needs and concerns of person with whom you are communicating
    4. Adaptability - ability to alter message in accordance with cues from receiver
    5. Credibility - must be believable
    6. Trustworthy

  C. Barriers and traps in verbal communication

    1. Over communicating - too wordy
    2. Under communicating - not enough information
    3. Using statements or ideas that are too generalized or ambiguous
    4. Making too many statements or asking too many questions at one time
    5. Connecting unrelated topics or questions
    6. Insensitivity to response of other person - avoid routine or automated speech/response
    7. Opinionated - inflexibility of attitudes, beliefs

II. Nonverbal Communication

A. Definition - any communication that does not involve speech; less consciously controlled than verbal communication

B. Channels of nonverbal communication

1. Kinetics - body movement, gestures

2. Paralanguage - voice quality, tone, nonlanguage noises, i.e., sobbing, grunting, etc.

3. Proxemics - spatial relationship maintained by persons involved in communication

4. Physical appearance, including manner of dress

5. Use of drawings, doodles, or symbols

C. Limitations of nonverbal communication

1. Cannot validate ideas or feelings being expressed

2. Nonverbal cues or responses may denote more than one thought or feeling.

D. Relationship between verbal and nonverbal system

1. Nonverbal cue may complement or communicate same thing as verbal message.

2. Nonverbal cue may modify or contradict verbal message.

3. Nonverbal messages relate and regulate verbal messages; cues tell people when to start or stop talking.

4. Nonverbal messages may be substituted for words, such as waving instead of speaking salutation.

E. Assessing nonverbal communication

1. Skills necessary for assessing nonverbal communication

a. Observation skills (senses of sight, hearing, touch, smell)

b. Interpretation skills (requires validation via communication)

2. Nurse must be aware of own nonverbal communication patterns

3. Systematic approach to assessing nonverbal communication

a. Overall physical appearance and dress

(1) General health characteristics

        - (2) Skin color - texture
        - (3) Deformities
        - (4) Weight
        - (5) Fingernails - hair, etc.
        - (6) Self-concept - via dress and adornment
    - b. Posture and gait
    - c. Facial expression
    - d. Movements and gesture

III. Therapeutic Communication

- A. Definition - an interaction between two people that is planned, has structure and is helpful or constructive
- B. Skills necessary in therapeutic communication
    - 1. Attentive, active listening vs. selective/passive listening
        - a. Face to face contact
        - b. Maintaining eye contact
        - c. Leaning toward the communicator
        - d. Nondefensive, open posture
        - e. Relaxed approach
    - 2. Responding effectively - responding to the content of the message and feelings expressed
- C. Effective techniques in therapeutic response/communications
    - 1. Impart information - offer suggestions, share facts
    - 2. Paraphrase - restate basic message in similar words
    - 3. Clarify - make message more understandable
    - 4. Open-ended questions and statements - invite exploration; receiver seeks elaboration, clarification, illustration of communicator's thoughts, feelings, ideas
    - 5. Focus - guide communication to one aspect; avoid vague, rambling conversation

6. Reflect - beyond acceptance and restating; validation

7. Process - comments that direct attention to interpersonal dynamics of nurse-client experience

8. Link - respond to client in way that ties together two events, experiences, feelings or persons (connect past experience with current behavior)

9. Structure - attempt to create order or evolve guidelines; help client become aware of problems and in what order problems should be dealt with; prioritize

10. Use of silence - motivates people to talk; allows client time to think by slowing pace of interaction

11. Summarize - bring together important points

IV. Nontherapeutic Communication

A. Definition - unstructured, unplanned communication and/or responses with no deliberate purpose other than social activity

B. Failure to listen

C. Unwarranted reassurance

D. Judgmental responses

1. Giving approval and/or disapproval

2. Giving advice

3. Stereotyping

E. Defensive responses

F. Agreeing and/or disagreeing

G. Hostile responses

1. Probing

2. Testing

3. Challenging

V. Communication and the Nurse-Patient Relationship

A. Rapport - sympathetic or harmonious relationship with another person

B. Developmental phases of the nurse-client relationship

1. Initiation phase
    a. A getting acquainted time which may last for a few minutes or take considerably longer
    b. Testing period - client may attempt to rebuff nurse during this phase or try to bluff the nurse
    c. Phase in which time frame for interaction is established
2. Working phase
    a. Time spent working constructively together
    b. Trust bond has formed
3. Termination phase
    a. Ending the relationship (sometimes painful)
    b. Should be mutually planned by client and nurse, usually established during initiation phase
    c. Use of therapeutic skills essential

VI. Summary and Conclusion

A. Verbal communication

B. Nonverbal communication

C. Therapeutic communication

D. Nontherapeutic communication

E. Communication and the nurse-client relationship

LESSON PLAN: 2

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATIONS

INTERACTION ITEMS:

1. How is the message received when nonverbal and verbal messages contradict each other?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Divide into groups of three - each group containing one interviewer, one observer, one interviewee. Assess nonverbal behavior of classmate interviewing another classmate. Relate observations to that classmate for validation. Change roles three times, so each student has a chance to play each role.
2. Have each student identify one nonverbal communication pattern he/she has.
3. Discuss the systematic approach to assessing nonverbal behavior.
4. Discuss the phases of the nurse-client relationship.

LESSON PLAN: 2

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATIONS

EVALUATION ITEMS

1. Define verbal communication.

2. Define nonverbal communication.

3. Identify three characteristics of effective verbal communication.
   a.
   b.
   c.
4. Identify three barriers to effective verbal communication.
   a.
   b.
   c.
5. Identify one way in which nonverbal messages are communicated.

6. Identify two skills necessary for the nurse to assess nonverbal behavior.
   a.
   b.

7. Explain the limitations of nonverbal communication.

   a.

   b.

8. Differentiate between therapeutic communication and nontherapeutic communication.

9. Identify two therapeutic communication techniques and describe each briefly.

   a.

   b.

10. Define rapport.

LESSON PLAN: 2

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATIONS

ANSWERS TO EVALUATION ITEMS

1. Verbal communication - conscious effort in choosing words; words vary according to culture, socioeconomic background, age, and education; either written or oral

2. Nonverbal communication - any communication that does not involve speech; less consciously controlled than verbal communication

3. Characteristics of effective verbal communication - any three of the following:
   a. Simplicity in choice of words - understandable and not overstated
   b. Clarity in presentation - noncomplex
   c. Timing and relevance - sensitivity to needs and concerns of person with whom you are communicating
   d. Adaptability - ability to alter message in accordance with cues from receiver
   e. Credibility - must be believable
   f. Trustworthy

4. Barriers to effective verbal communication - any three of the following:
   a. Over communicating - too wordy
   b. Under communicating - not enough information
   c. Using statements or ideas that are too generalized or ambiguous
   d. Making too many statements or asking too many questions at one time
   e. Connecting unrelated topics or questions
   f. Insensitivity to response of other person - avoid routine or automated speech/response
   g. Opinionated - inflexibility of attitudes, beliefs

5. Channels of nonverbal communication - one of the following:
   a. Kinetics - body movement, gestures
   b. Paralanguage - voice quality, tone, nonlanguage noises, i.e., sobbing, grunting, etc.
   c. Proxemics - spatial relationship maintained by persons involved in communication
   d. Physical appearance, including manner of dress
   e. Use of drawings, doodles, or symbols

6. Assessing nonverbal communication
   a. Observation skills (senses of sight, hearing touch, smell)
   b. Interpretation skills (requires validation via communication)

7. Limitations of nonverbal communication
    a. Cannot validate ideas or feelings being expressed
    b. Nonverbal cues or responses may denote more than one thought or feeling

8. Therapeutic communication is an interaction between two people that is planned, has structure, and is helpful or constructive, while nontherapeutic communication is unstructured, unplanned communication and/or responses with no deliberate purpose other than social activity.

9. Therapeutic communication techniques - any two of the following:
    a. Impart information - offer suggestions, share facts
    b. Paraphrase - restate basic message in similar words
    c. Clarify - make message more understandable
    d. Open-ended questions and statements - invite exploration; receiver seeks elaboration, clarification, illustration of communicator's thoughts, feelings, ideas
    e. Focus - guide communication to one aspect; avoid vague, rambling conversation
    f. Reflect - beyond acceptance and restating; validation
    g. Process - comments that direct attention to interpersonal dynamics of nurse-client experience
    h. Link - respond to client in way that ties together two events, experiences, feelings or persons (connect past experience with current behavior)
    i. Structure - attempt to create order or evolve guidelines; help client become aware of problems and in what order problems should be dealt with; prioritize
    j. Use of silence - motivates people to talk; allows client time to think by slowing pace of interaction
    k. Summarize - bring together important points

10. Rapport - sympathetic or harmonious relationship with another person

COMMUNICATION

THERAPEUTIC TECHNIQUES

1. SILENCE
   a. Encourages patient to initiate discussion of a topic of concern to him/her
   b. Provides an opportunity for patient to collect and organize his/her thoughts
   c. Shows acceptance and interest
   d. Provides opportunity for nurse to observe nonverbal communication

2. ACCEPTANCE
   a. Gives indication to patient that nurse is listening
   b. Is nonjudgmental (doesn't indicate agreement)

   Examples: "Yes," "uh-huh," "I follow what you are saying," or nonverbal nodding of head

3. GIVING RECOGNITION
   a. Acknowledges patient as an individual
   b. Indicates nurse's awareness
   c. Takes notice of a past change, or happening

   Examples: "Good morning, Mr. Smith. You've completed your OT project."

4. OFFERING SELF
   a. Makes nurse available to the patient
   b. Lets patient know how long nurse will be with him/her.

   Examples: "I'll sit with you for 10 minutes." "I'm interested in your comfort."

5. GIVING A BROAD OPENING
   Allows patient to take the initiative in introducing the topic of conversation

   Examples: "What would you like to talk about?" "Where would you like to begin?"

6. OFFERING GENERAL LEADS
   a. Gives encouragement to continue
   b. Leaves direction of conversation to patient
   c. Indicates nurse is listening and interested

   Examples: "Go on." "And then. . ."

7. PLACE THE EVENT IN TIME, OR IN SEQUENCE
   a. Clarifies the relationship of events in time
   b. Helps patient and nurse see events in perspective

   Examples: "What seemed to lead up to. . .?" "Was this before or after. . .?"

8. MAKING AN OBSERVATION
   a. Verbalize what is perceived at the present time
   b. Encourages mutual understanding of feelings or behavior
   c. Open-ended statements

   Examples: "You appear tense." "I notice you're biting your lips."

9. ENCOURAGE DESCRIPTION OF PERCEPTIONS
   a. Asks patient to verbalize what he/she perceives
   b. Helps nurse to see things as patient sees them and gives insight regarding patient's behavior
   c. Helps patient feel free to talk about his/her feelings rather than acting them out

   Examples: "Tell me when you feel anxious." "What is happening to you?"

10. ENCOURAGE A COMPARISON
   a. Seeks similarities and differences
   b. Brings out many recurring themes and promotes evaluation of these events.

   Examples: "Was this something like . . .?" "Have you had a similar experience?"

11. RESTATING
   a. Repeats the main idea or phrase expressed by the patient
   b. Gives evidence patient's idea has been effectively communicated
   c. Encourages patient to elaborate
   d. Can seem like a mimic, if used too often

   Example: Patient: "I stay awake all night."
   Nurse: "You have difficulty sleeping?"

12. REFLECTING
   a. Directs question, feelings and ideas back to the patient
   b. Indicates patient's point of view has value

   Example: Patient "Do you think I should tell the M. D.?"
   Nurse: "Do you think you should?"

13. FOCUSING
   a. Concentrates on a single point
   b. Is useful when patient jumps from one topic to another

   Example: "This seems worth looking at more closely."

14. EXPLORING
   a. Delves further into a subject or idea
   b. Refrain from probing, or prying. If patient doesn't want to elaborate, respect his/her wishes.

   Examples: "Tell me more about that." "Would you describe it more fully?"

15. GIVING INFORMATION
    a. Provides the facts the patient needs to know
    b. Builds trust, lessens anxiety and fear of the unknown
    c. Gives the patient more knowledge

    Examples: "My name is . . ." "Visiting hours are . . ."

16. SEEKING CLARIFICATION
    a. Clarifies that which seems vague
    b. Not necessary to understand everything the patient says as long as nurse is open and honest

    Examples: "I'm not sure that I follow." "Who are they?"

17. PRESENTING REALITY
    a. Indicates that which is real to the patient when he/she is misinterpreting reality
    b. Offers for consideration that which is real
    c. Indicates an alternate line of thought for the patient to consider
    d. Intent is not to "convince" the patient that he/she is in error

    Example: "I see no one else in the room."

18. VOICING DOUBT
    a. Expresses uncertainty as to the reality of the patient's perceptions
    b. Is a response to distortions of reality
    c. Encourages patient to reconsider and re-evaluate what has occurred
    d. Do not let distortions of reality pass without comment; however, do not agree or disagree.

    Examples: "Isn't that unusual?" "Really?"

19. SEEKING CONSENSUAL VALIDATION
    a. Searches for mutual understanding of words and/or ideas
    b. Contributes to meaningful communication

    Examples: "Tell me whether my understanding of it agrees with yours."
    "Are you using this word to convey the idea . . .?"

20. VERBALIZING THE IMPLIED
    a. Voices what the patient has hinted at or suggested
    b. Take care to express only that which is fairly obvious (avoid interpreting)

    Examples: Patient: "I can't talk to you or anyone."
    Nurse: "Is it your feeling that no one understands?"

    Patient: "My wife pushes me around, just like my mother and sister."
    Nurse: "Is it your impression that women are domineering?"

21. ENCOURAGING EVALUATION
    a. Asks the patient to appraise the quality of his/her experience
    b. Helps patient to consider people and events in light of his/her own values

    Examples: "What are your feelings in regard to . . . ?"
    "Does this contribute to your discomfort?"

22. ATTEMPTING TO TRANSLATE INTO FEELINGS
    a. Verbalizes feelings which are indirectly expressed by the patient
    b. Focuses on what the patient must be feeling that causes him/her to express the feeling in a particular way
    c. Responds primarily to the feelings expressed rather than content

    Example: Patient: "I'm dead."
    Nurse: "Is it that life seems meaningless?"

    Patient: "I'm way out in the ocean."
    Nurse: "Do you feel deserted?"

23. SUGGESTING COLLABORATION
    a. Offers to share, strive, and work together to the patient's benefit
    b. Offers to do things with the patient, not for him/her

    Example: "Perhaps you and I can discuss and discover what produces your feelings of nervousness."

24. SUMMARIZING
    a. Organizes and sums up that which has gone before
    b. Seeks to bring together the important points of discussion

    Examples: "We have talked about . . ." "You said that . . ."
    "During the past 20 minutes you and I have discussed . . ."

25. ENCOURAGING FORMULATION OF A PLAN OF ACTION
    a. Asks patient to consider types of behavior which are likely to be appropriate in future situations
    b. Does not solve problem, but guides behavior in future interpersonal exchanges

    Examples: "What could you do to let your anger out harmlessly?"
    "Next time this comes up, what might you do to handle it?"

26. VERBAL POSITIVE APPROACH
    Examples: "Let's play cards." "It is time for you to go to OT."

NONTHERAPEUTIC TECHNIQUES

1. FALSE REASSURANCE
    a. Indicates that there is no cause for anxiety, or worry
    b. Implies that there isn't sufficient reason for anxiety to exist
    c. Devaluates the patient's own feelings

    Examples: "I wouldn't worry about . . ."
    "You're coming along fine."

2. GIVING APPROVAL
   a. Sanctions the patient's ideas or behavior
   b. Implies the opposite is bad
   c. Leads patient to strive for praise rather than progress

   Examples: "That's good." "I'm glad that you . . ."

3. REJECTING
   a. Refuses to consider the patient's conversation
   b. Causes therapeutic interaction to cease (patient feels rejected)

   Examples: "Let's not discuss . . ." "I don't want to hear about . . ."

4. DISAPPROVAL
   a. Denounces patient's ideas or behavior
   b. Implies nurse has the right to pass judgment on patient's thoughts
   c. Implies patient is expected to please the nurse
   d. Informs patient of effects of his/her actions instead of offering judgment

   Examples: "That's bad." "I'd rather you wouldn't . . ."

5. AGREEING
   a. Indicates accord with the patient
   b. Indicates right and wrong judgment
   c. Feels he/she is right because he/she is in agreement with nurse
   d. Feels he/she can't change his/her mind without admitting error

   Examples: "That's right." "I agree."

6. DISAGREEING
   a. Opposes the patient's ideas
   b. Implies the patient is wrong
   c. Places patient on defensive

   Examples: "That's wrong." "I definitely disagree with . . ."

7. ADVISING
   a. Tells the patient what to do
   b. Implies nurse knows what is best for the patient
   c. Fosters dependency

   Examples: "I think you should . . ." "Why don't you . . ."

8. PROBING
   a. Persistent questioning
   b. Makes patient feel used
   c. Places the patient on defensive

   Examples: "Now tell me about . . ."
   "What made you and your husband separate?"

9. CHALLENGING
   - a. Demands proof from the patient
   - b. Causes patient to expand his/her misinterpretation of reality to support his/her point of view

   Examples: "But, how can you be the President of the United States?"
   "If you're dead, why is your heart beating?

10. TESTING
    Appraises the patient's degree of insight

    Examples: "What day is this?" "What's my name?"

11. DEFENDING
    - a. Attempts to protect someone or something from verbal attack
    - b. Implies that patient has no right to express his/her impressions

    Examples: "This hospital has a fine reputation."
    "No one here would lie to you."

12. REQUESTING AN EXPLANATION
    - a. Asks patient to provide the reasons for thought, feeling, behavior and events
    - b. Asks patient to explain "why" (Patient without insight doesn't know why)

    Examples: "Why do you think that?" "Why do you feel this way?"

13. BELITTLING FEELINGS EXPRESSED
    - a. Misjudges the degree of the patient's discomfort
    - b. Indicates lack of understanding

    Example: Patient: "I have nothing to live for. . . I wish I were dead."
    Nurse: "Everyone gets down in the dumps."

14. MAKING STEREOTYPED COMMENTS
    - a. Offers meaningless cliches or trite expressions
    - b. Empty conversation from the nurse often encourages the same from the patient.

    Examples: "Nice weather we're having." "I'm fine, how are you?"

15. GIVING LITERAL RESPONSES
    - a. Responds to a figurative comment as though it were a statement of fact
    - b. Indicates inability to understand what is being expressed

    Example: Patient: "I'm an Easter Egg."
    Nurse: "What shade?" -or- "You don't look like one."

16. USING DENIAL
Refuses to admit that a problem exists

Examples: Patient: "I'm nothing."
Nurse: "Of course you're something, because everybody is something."
Patient: "I'm dead."
Nurse: "Don't be silly."

17. INTERPRETING
- a. Seeks to make conscious that which is unconscious
- b. Tells the patient the meaning of his/her behavior
- c. Prevents patient from achieving insight on his/her own
- d. The interpretation may be incorrect
- e. Patient may not be ready for it

Example: "What you really mean is . . ."
"Unconsciously, you're saying . . ."

18. INTRODUCING AN UNRELATED TOPIC
- a. Changes the subject
- b. Takes the initiative of directing the conversation away from the patient
- c. Shows that the nurse is uncomfortable

Examples: Patient: "I'd like to die."
Nurse: "Did you have visitors last weekend?"

Adapted from a handout prepared by St. Mary's College of O'Fallon Nursing School Faculty

LESSON PLAN: 3

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATION

SCOPE OF UNIT:

This unit is designed to teach the student essential facts about the communication process and effective and ineffective methods of communicating with clients and with other members of the health care team. The teaching/learning process will be included to guide the student's development of a client teaching plan. Process recordings will be used to assess and evaluate student-client interactions. The unit will help the student develop a beginning understanding of the documentation process on the professional level in relation to client records.

INFORMATION TOPIC: X OR DEMONSTRATION:

THE EFFECTS OF COPING MECHANISMS ON COMMUNICATION
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Define the following terms:

    a. Frustration
    b. Threat
    c. Conflict
    d. Anxiety
    e. Fear
    f. Stress

2. Define the coping mechanisms listed below by which the personality attempts to defend and/or enhance itself, mediate conflicting drives, and allay tensions.

    a. Repression
    b. Identification (empathy)
    c. Reaction formation
    d. Compensation
    e. Rationalization
    f. Substitution
    g. Displacement
    h. Projection
    i. Regression
    j. Denial
    k. Sublimation
    l. Suppression
    m. Introjection
    n. Conversion
    o. Fantasy

3. Discuss the client's response to anxiety.

4. Discuss the client's response to stress.

5. Identify methods of assisting clients to adapt to stress.

6. Describe:

   a. Approach-approach conflict

   b. Approach-avoidance conflict

   c. Avoidance-avoidance conflict

7. Given a situation describing a client's behavior, recall intervention techniques identified in Lesson II-2 for guidance in communicating with clients who are stressed or anxious.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Problem Solving Behaviors
2. HO 2: Problem Avoidance Behaviors

INFORMATIONAL ASSIGNMENT: (Student)

Kozier, B. and G. Erb. Fundamentals of Nursing: Concepts and Procedures. 2nd ed. Menlo Park, CA: Addison-Wesley Co., 1983. pp. 359-388.

Wolff, L., et al. Fundamentals of Nursing. 7th ed. New York: J.B. Lippincott Co., 1983. pp. 224-235.

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Sundeen, et al. Nurse-Client Interaction. St. Louis: C.V. Mosby Co., 1976.

Wilson, Holly S. and Kneisl. Psychiatric Nursing. 2nd ed. Menlo Park, CA: Addison-Wesley Co., 1983.

INTRODUCTION:

This lesson concerns clients' responses to conflict, anxiety, stress, and fear, and the psychological mechanisms used to protect their self-esteem and sense of security.

LESSON PLAN: 3

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATION

INFORMATION TOPIC: II-3

OUTLINE: (Key Points)

I. Definitions

   A. Coping mechanisms - behavior patterns used daily to adapt to life situations

   B. Frustration - increased emotional tension due to inability to meet goals

   C. Threat - anticipation of harm

   D. Conflict - opposing goals make threat or frustration inevitable

   E. Fear - reaction to real danger

   F. Anxiety

      1. Persistent feeling of dread, apprehension, and impending disaster

      2. By-product of frustration, threat or conflict

      3. Client response may be constructive or destructive

   G. Stress - (Selye) nonspecific response of the body to any demand made upon it

II. Client Responses to Stress

   A. General Adaptation Syndrome (GAS)

      1. Developed by Hans Selye

      2. Affects the gastrointestinal tract, adrenals, and thymus

      3. Three stages

         a. Alarm reaction - fight/flight

         b. Stage of resistance - cannot be sustained indefinitely

         c. Stage of exhaustion - can result in death

      4. General response of body such as the endocrine adaptive response

B. Local Adaptation Syndrome (LAS)

1. Three stages
    a. Alarm reaction
    b. Stage of resistance
    c. Stage of exhaustion
2. Local response by one organ or one part of the body such as the inflammatory response

C. Signs and symptoms of increased stress

1. Physiological
    a. Pupils dilate - increases visual perception
    b. Sweat production (diaphoresis) - increases body heat to increase metabolism
    c. Heart rate increases - transports nutrients and by-products of metabolism more efficiently
    d. Skin pales - constricted blood vessels
    e. Blood pressure elevates - constricted blood flow to brain and muscles
    f. Respiratory rate and depth increases - adrenalin dilates bronchioles
    g. Urinary output either frequent or decreased
    h. Mouth dry
    i. Decreased peristalsis
    j. Increased mental alertness
    k. Increased muscle tension
2. Psychological
    a. Reduction of intellectual processes
    b. Increased self-sensitivity
    c. Decreased ability to cope with or master tasks
    d. Decreased sense of personal effectiveness

III. Physiologic Adaptations To Stress

A. Endocrine - glands which secrete hormones and are catagorized as local and general

1. Local hormones stimulate cells near the endocrine gland

2. General hormones are secreted directly into the bloodstream

B. Neurologic adaptive response - involves the autonomic nervous system divisions which operate involuntarily and control many internal functions such as heart and respiratory rates

1. Parasympathetic

2. Sympathetic

C. Inflammatory adaptive response

1. The body reacts to injury by:

a. Diluting or destroying the injurious agent

b. Preventing spread of injury

c. Promoting repair of damaged tissue

2. The five signs of inflammation are:

a. Pain

b. Swelling

c. Redness

d. Heat

e. Impaired function

D. Immunologic adaptive response - body responds to antigens (foreign material) by producing antibodies to counteract the antigens

IV. Psychologic Adaptations To Stress

A. Repression - to put out of consciousness those desires, impulses, or thoughts that conflict with the image we have of ourselves

B. Identification (empathy) - to relate closely to roles, attitudes, and behavior patterns of an admired person, i.e., parent

C. Reaction formation - behavior that is exactly opposite of what a person would typically tend to show

D. Compensation - substitution phenomena; behavior to compensate for lack of some characteristic

E. Rationalization - Rational, intellectual reasons for justification of behavior

F. Substitution - To prevent frustration, an alternate, attainable goal is chosen

G. Displacement - Emotional feeling transferred from actual object to substitute

H. Projection - Attributing characteristics to others which one does not want to admit are one's own

I. Regression - to adopt behavior of earlier time of life

J. Denial - to disown undesirable thoughts, facts, deeds, etc.

K. Sublimation - energy of unacceptable impulses redirected into socially useful goals

L. Suppression - to consciously put feeling or thought out of mind

M. Introjection - traits of another person are taken into oneself

N. Conversion - transform mental conflict into physical symptoms

V. Assisting Clients to Adapt to Stress

A. The nurse must be able to recognize stress and assist clients to adapt.

B. If the nurse is sensitive to a client's needs and reactions he/she can choose the methods most effective for that client.

C. Methods of helping clients adapt to stress

1. Sensitivity to situations that increase stress
2. Orient client to hospital
3. Support family
4. Encourage client to ventilate feelings
5. Assist client to maintain identity
6. Client participates in plan of care
7. Repeat information
8. Decrease admission procedure time (delay questioning)

9. Encourage activity
10. Expectations in client's capability
11. Community agency consideration for family
12. Reinforce positive environmental factors
13. Provide information
14. Assist with correct appraisal of situations
15. Provide environment for independent function
16. Visit other clients in similar situation
17. Communicate competency, understanding and empathy

VI. Conflict

A. Conflict occurs when a person has opposing goals - there are three types:

1. Approach-approach - person has two desirable though incompatible goals
2. Approach-avoidance - occurs when person wants to attain and avoid goal at same time
3. Avoidance-avoidance - occurs when person must choose between two undesirable goals

B. Intervention techniques (Refer to Lesson II-2)

VII. Summary and Conclusion

A. Definitions

B. Client responses to stress

C. Physiologic adaptations to stress

D. Psychologic adaptations to stress

E. Assisting clients to adapt to stress

F. Conflict

LESSON PLAN: 3

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATION

INTERACTION ITEMS:

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Identify methods you use to cope with clients exhibiting stress - relate the specific situation such as admission to hospital, injury, exam.
2. Discuss the patient's response to anxiety, stress.
3. Give students a client situation, describe an anxious client's behavior and have them recall intervention techniques - good for role-play.

LESSON PLAN: 3

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATION

EVALUATION ITEMS

1. Define the following terms:
   - a. Stress
   - b. Anxiety
   - c. Rationalization
   - d. Identification
   - e. Reaction formation
   - f. Conversion
   - g. Regression
   - h. Sublimation

2. Identify five ways to assist the client to adapt to stress.

   a.

   b.

   c.

   d.

   e.

3. Describe the situation of approach-avoidance conflict.

LESSON PLAN: 3

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATION

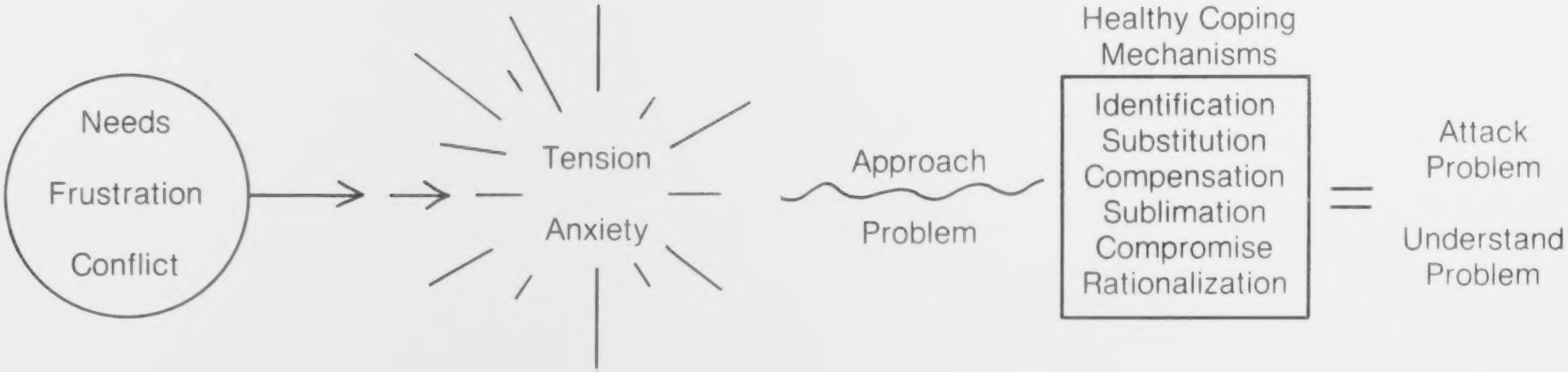
ANSWERS TO EVALUATION ITEMS

1. a. Stress - (Selye) nonspecific response of the body to any demand made upon it
   b. Anxiety - persistent feeling of dread, apprehension, and impending disaster
   c. Rationalization - rational, intellectual reasons for justification of behavior
   d. Identification - relate closely to roles, attitudes, and behavior patterns of an admired person, i.e., parent
   e. Reaction formation - behavior that is exactly opposite of what a person would typically tend to show
   f. Conversion - transform mental conflict into physical symptoms
   g. Regression - to adopt behavior of earlier time of life
   h. Sublimation - energy of unacceptable impulses redirected into socially useful goals

2. Methods of assisting clients to adapt to stress - any five of the following:
   a. Sensitivity to situations that increase stress
   b. Orient client to hospital
   c. Support family
   d. Encourage client to ventilate feelings
   e. Assist client to maintain identity
   f. Client participates in plan of care
   g. Repeat information
   h. Decrease admission procedure time (delay questioning)
   i. Encourage activity
   j. Expectations in client's capability
   k. Community agency consideration for family
   l. Reinforce positive environmental factors
   m. Provide information
   n. Assist with correct appraisal of situations
   o. Provide environment for independent function
   p. Visit other clients in similar situation
   q. Communicate competency, understanding and empathy

3. Approach - avoidance conflict occurs when a person wants to attain and avoid goal at the same time.

Problem Solving Behaviors



Needs
Frustration
Conflict

Tension
Anxiety

Approach
Problem

Healthy Coping Mechanisms

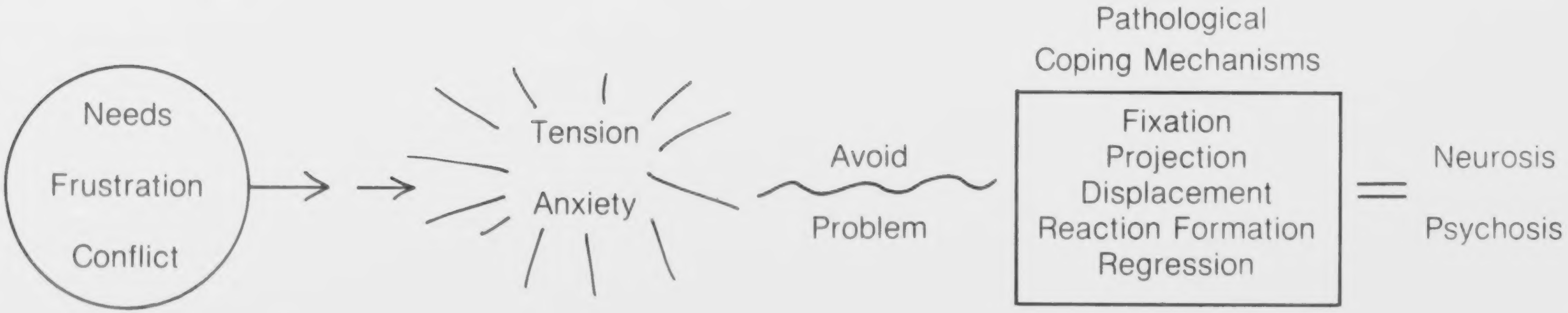
- Identification
- Substitution
- Compensation
- Sublimation
- Compromise
- Rationalization

=

Attack Problem

Understand Problem

Problem Avoidance Behaviors



Needs
Frustration
Conflict

Tension
Anxiety

Avoid
Problem

Pathological
Coping Mechanisms

Fixation
Projection
Displacement
Reaction Formation
Regression

Neurosis
Psychosis

LESSON PLAN: 4

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATION

SCOPE OF UNIT:

This unit is designed to teach the student essential facts about the communication process and effective and ineffective methods of communicating with clients and with other members of the health care team. The teaching/learning process will be included to guide the student's development of a client teaching plan. Process recordings will be used to assess and evaluate student-client interactions. The unit will help the student develop a beginning understanding of the documentation process on the professional level in relation to client records.

INFORMATION TOPIC: X OR DEMONSTRATION:

PROCESS RECORDINGS
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Define the following terms:
    a. Nurse-client relationship
    b. Helping relationship
    c. Active listening
    d. Interview
    e. Process recording
2. Identify the goal of a nurse-client relationship.
3. Describe self-awareness and relate its importance to development of a helping relationship.
4. Identify requirements for listening and ways to develop listening skills.
5. Identify six purposes of the interview.
6. Describe the purpose of a process recording and how a process recording can improve a nurse-client relationship.

7. List rules for a process recording.

8. Identify phases of a therapeutic relationship.

9. Demonstrate techniques and skills in the interview process through interaction and process recording.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO I: The Three Column Approach to Process
2. Trainex 3505 - Process Recording Guide
3. Trainex 604 - Nursing History: Foundation for Total Patient Care
4. Trainex 605 - Nursing History: Interviewing Techniques
5. Trainex 606 - Nursing History: Guidelines for Accuracy
6. Trainex 607 - Nursing History: Interpretation of Patient Responses
7. Trainex 608 - Data Analysis and the Nursing Diagnosis

INFORMATIONAL ASSIGNMENT: (Student)

Kozier, B. and G. Erb. Fundamentals of Nursing: Concepts and Procedures. 2nd ed. Menlo Park, CA: Addison-Wesley Co., 1983. pp. 372-385.

Wilson, Holly S. & Kneizl. Psychiatric Nursing. 2nd ed. Menlo Park, CA: Addison-Wesley Co., 1983. pp. 131-134.

REFERENCES: (Instructor's Additional Information)

Bernstein, Lewis, et. al. Interviewing: A Guide for Health Professionals. New York: Appleton-Century-Cofts, 1974.

Du Gas, Beverly W. Introduction To Patient Care. 3rd ed. Philadelphia: W.B. Saunders Co., 1977.

Hein, E.C. Communication in Nursing Practice. 2nd ed. Boston: Little, Brown & Co., 1980.

Kemp, Brenda and Adele Pillitteri. Fundamentals of Nursing. Boston: Little, Brown & Co., 1984.

Smith, Voncil M. and Thelma A. Bass. Communication for Health Professionals. Philadelphia: J.B. Lippincott Co., 1979.

Sorensen, Karen and Joan Luckmann. Basic Nursing. Philadelphia: W.B. Saunders Co., 1979.

Sundeen, et al. Nurse-Client Interaction. St. Louis: C.V. Mosby Co., 1976.

INTRODUCTION:

This lesson concerns the nurse-client interaction and process recording, a method by which skills necessary for a therapeutic nurse-client relationship can be developed.

LESSON PLAN: 4

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATION

INFORMATION TOPIC: II-4

OUTLINE: (Key Points)

I. Definitions

   A. Nurse-client relationship - a nurturing, caring, helping relationship the goal of which is to assist the client to identify and meet his/her own needs; characterized by nurse's attitude of:

      1. Sensitivity
      2. Acceptance
      3. Empathy
      4. Honesty
      5. Understanding

   B. Helping relationship or therapeutic relationship - a growth-facilitating process to maximize client's potential

   C. Interview - verbal or nonverbal communication, the purpose of which is to exchange pertinent information

   D. Active listening - to listen in such a way that the listener can accurately understand what is being communicated

   E. Process recording - the written record of a nurse-client interaction; includes analysis of interaction

   F. Self-awareness - an understanding of personal behavior, and to a degree, understanding what motivates that behavior; implications to nursing include:

      1. Nurse's feelings can cloud perception of the client's situation.

      2. Nurse's unmet needs may interfere with perception of the client's needs.

      3. Accurate self-perception is essential if growth is to occur.

      4. Beliefs guide behavior; therefore, without knowledge of self it is difficult to state beliefs to guide nursing practice

II. Listening

   A. Requirements for active listening

        1. Conscious focus on client
        2. Patient's needs and interests primary
        3. Adequate time
        4. Complete attention
        5. Privacy
        6. Eye contact, possibly touch
        7. Energy - a demanding process, should not be viewed as break time

    B. Listening skills

        1. Want to listen
        2. Develop your interests
        3. Look at the content of the message
        4. Hear the speaker out
        5. Focus on ideas
        6. Use an appropriate note system
        7. Adjust to distractions
        8. Broaden your knowledge
        9. Maintain objectivity
        10. Recognize that speech rate is slower than your thoughts

III. Purpose of Interview

    A. Gather information
    B. Share information
    C. Facilitate interpersonal relationship
    D. Express feelings
    E. Explore feelings
    F. Promote client participation in problem solving

IV. Purpose of Process Recordings

    A. Observe consequences of communication

B. Increase awareness of nonverbal communication

C. View self with greater objectivity

D. Improve communication skills - a process recording is done to aid the nurse to look critically at the communication process

   1. What the nurse says to the client
   2. What the client says to the nurse
   3. How the client's behavior changes by what is being said
   4. How the nurse can be therapeutic
   5. How the nurse can eliminate or prevent barriers to communication
   6. How to develop a professional relationship rather than social relationship
   7. Gain new information and evolve new insights
   8. Disciplines the nurse to look beyond the obvious and to take time to explore his/her feelings
   9. Assess strengths and weakness

V. Rules For Writing a Process Recording

A. Length of the interaction will vary.

   1. Recordings should focus on 5-10 minutes of the interaction when the nurse seeks to identify, clarify, or minister to emotional needs.
   2. Where health teaching is being pursued, use the three column approach. (HO 1)

B. All interactions should include the following:

   1. Goal - purpose of conversation
   2. Setting
      a. Where interaction takes place
      b. What has already transpired
      c. Phase of the therapeutic relationship
      d. Emotional tone already established
      e. Description of client's appearance
   3. Summary

        - a. Was goal accomplished?
        - b. What was the significance of the interaction?

- C. Record conversation with client, reproducing as closely as possible the actual spoken words of both nurse and client.
- D. For greater accuracy, record conversation as soon as possible after it has occurred.
- E. Record both verbal and nonverbal interactions.
- F. Record verbal and nonverbal impressions received from the client.
- G. Record feelings and attitudes the nurse conveyed to the client.
- H. Review the written interaction and analyze what took place
    - 1. Identify various techniques used
        - a. Therapeutic
        - b. Nontherapeutic
    - 2. Client's response
        - a. How did the client respond?
        - b. Did the nurse encourage the client to express himself/herself?
        - c. Did the nurse demonstrate caring?
        - d. What caused the response?
    - 3. Perceptions
        - a. What clues did client give about his/her feelings?
        - b. What did the nurse do about them?
        - c. What could the nurse have done?
        - d. What clues did the client receive?
        - e. How did the client "see" the nurse?
        - f. What can the nurse do to foster the image he/she wishes to create?
    - 4. Evaluation
        - a. What else could the nurse have said?

    - b. Was there a better way to express what the nurse said?
    - c. Was there a better way to encourage the client to express himself/herself?

VI. Phases of a Therapeutic Relationship

- A. Preinteraction phase
  - 1. Information gathering
    - a. Name
    - b. Age
    - c. Address
    - d. Medical history and/or social history
  - 2. Identify potential areas of concern
  - 3. Develop plan for initial interaction
- B. Initiation phase - three-stage orientation phase or prehelping phase
  - 1. Entry
    - a. Prepares client
    - b. Opens relationship
  - 2. Clarification - state problem or concern
  - 3. Structure - formulate contract
- C. Working phase - phase when tasks outlined in introductory phase are accomplished
  - 1. Responding and exploring
    - a. Listening, attending with appropriate response to show understanding, respect, and genuineness
    - b. Help client be specific
  - 2. Integrative understanding and dynamic self-understanding -clients achieve an objective, i.e., understanding themselves and their world
  - 3. Facilitating and taking action - clients make decisions and take action with collaboration from nurse
- D. Termination phase - summary or review

VII. Summary and Conclusion

A. Definitions

B. Listening

C. Purpose of interview

D. Purpose of process recordings

E. Rules for writing a process recording

F. Phases of a therapeutic relationship

LESSON PLAN: 4

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATION

INTERACTION ITEMS:

1. What are some personal behaviors, feelings, perceptions which could interfere with development of a nurse-client relationship?
2. What are possible client reactions related to interview objectives?
3. What are several approaches to clients that would initiate a successful interaction?
4. What are the rules for a process recording?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Review therapeutic and nontherapeutic techniques
2. Role-play nurse-client interaction.
3. Conduct an interview with a client utilizing therapeutic techniques. Do a process recording following the rules for writing an interaction. Record approximately 5-10 minutes of your interaction utilizing the three column approach to format (HO 1). Discuss your interaction and paper with your instructor. You may need to repeat this exercise two or three times.

LESSON PLAN: 4

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATION

EVALUATION ITEMS

1. Define the following terms:
   a. Nurse-client relationship
   b. Helping relationship
   c. Interview
   d. Active listening
   e. Process recording
2. Identify the goal of the nurse-client relationship.
3. Describe how self-awareness aids a helping relationship.
4. Identify three requirements for listening.
   a.
   b.
   c.
5. Two purposes of the interview are gathering and sharing information. True or False? (Circle one.)
6. A purpose for the process recording is to evolve new insights into the communication process. True or False? (Circle one.)

7. List the four phases of a therapeutic relationship.

a.

b.

c.

d.

LESSON PLAN: 4

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATION

ANSWERS TO EVALUATION ITEMS

1. Definition
    a. Nurse-client relationship - a nurturing, caring, helping relationship
    b. Helping relationship - a growth-facilitating process to maximize client's potential
    c. Interview - verbal or nonverbal communication, the purpose of which is to exchange pertinent information
    d. Active listening - to listen in such a way that the listener can accurately understand what is being communicated
    e. Process recording - written record of nurse-client interaction with analysis

2. Assist client to identify and meet his/her own needs.

3. You can accurately assess your own behavior, causes of that behavior, client's behaviors and needs.

4. Requirements for listening - any three of the following:
    a. Conscious focus on client
    b. Client's needs and interests primary
    c. Adequate time
    d. Complete attention
    e. Privacy
    f. Eye contact, possibly touch
    g. Energy - a demanding process, should not be viewed as break time

5. True

6. True

7. Four phases of a therapeutic relationship
    a. Preinteraction phase
    b. Initiation phase
    c. Working phase
    d. Termination phase

The Three Column Approach to Process

NURSE	CLIENT	ANALYSIS
Communication (verbal and nonverbal)	Communication (verbal and nonverbal)	Of patient's communication of nurse's communication
Example:		
1. Good morning, how are you feeling today?	2. Good morning, oh okay I guess (trying to smile but looks sad).	2. Something seems to be bothering Mrs. A. today?
3. You seem a little sad.		3. Using observation to try to get client to express her feelings.
	4. Not really sad, just tired.	
5. Didn't you sleep well last night?		
	6. No, I tossed and turned all night.	
7. How come?		7. This question was probably too abrupt, maybe I could have said "Do you know why you were unable to sleep?"

Summary:
at end of interaction

LESSON PLAN: 5

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATION

SCOPE OF UNIT:

This unit is designed to teach the student essential facts about the communication process and effective and ineffective methods of communicating with clients and with other members of the health care team. The teaching/learning process will be included to guide the student's development of a client teaching plan. Process recordings will be used to assess and evaluate student-client interactions. The unit will help the student develop a beginning understanding of the documentation process on the professional level in relation to client records.

INFORMATION TOPIC: X OR DEMONSTRATION:

DOCUMENTATION - RECORDING

(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Identify reasons for records.
2. Match the following terms to correct definitions:
   a. Audit
   b. Data base
   c. Peer review
   d. Problem oriented record (POR)
3. Identify the six parts of a traditional client record.
4. List three advantages of the Kardex record.
5. Identify guidelines for recording.
6. Identify legal factors involved in recording.
7. Identify general areas with specific content for each to be included in charting nurses' notes.
8. Given the information in HO 1, list specific content included when charting observations for a particular area of the body.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Charting Guidelines
2. Trainex 405 - Observation and Charting
3. Trainex 181 - Maintaining the Patient's Chart
4. Trainex 612 - Nurse, Ethics, and the Law: Nursing Notes

INFORMATIONAL ASSIGNMENT: (Student)

Atkinson, Leslie D. and Mary Ellen Murray. Fundamentals of Nursing. New York: MacMillan Publishing Co., Inc. 1985. pp. 135-146.

Kozier, Barbara and Glenora Erb. Fundamentals of Nursing: Concepts and Procedures. 2nd ed. Menlo Park, CA: Addison-Wesley Co. 1983. pp. 425-444.

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Sundeen, et al. Nurse-Client Interaction. St. Louis: C.V. Mosby Co. 1976.

Wilson, Holly S. and Kneisl. Psychiatric Nursing. 2nd ed. Menlo Park, CA: Addison-Wesley Co. 1983.

INTRODUCTION:

This lesson concerns the importance of proper documentation, and suggests guidelines for record keeping.

LESSON PLAN: 5

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATION

INFORMATION TOPIC: II-5

OUTLINE: (Key Points)

I. Definitions

  A. Audit - a review of the client record to assess the quality of care the client receives and related competencies of people giving the care

  B. Data base - all information known about the client when he/she first enters the health care agency

  C. Peer review (nursing audit) - monitors nursing care

    1. Data base

    2. Identification of health problems

    3. Goals of nursing intervention

    4. Nursing interventions chosen

    5. Evaluation of goal attainment

    6. Nursing skills, judgment and knowledge

  D. Problem oriented record (POR) - a recording system providing a client-centered, problem-solving approach to care

II. Reasons for Records

  A. Communication - to convey meaningful information among health team members

  B. Legal documentation - admissible in court as evidence; property of the agency, but client has a right to information in the record

  C. Research - information provides tool for future research into disease, drugs, treatments, etc.

  D. Statistics - help anticipate and plan for future needs

  E. Education - students from all areas of the health discipline utilize records as an educational tool

  F. Audit - monitor quality of care

III. Problem Oriented Record (POR)

A. Defined data base - all information known about client upon admission to hospital

B. Complete problem list - problems presented by client

1. Socioeconomic

2. Psychological

3. Physiological

C. Initial plan for each identified problem

1. Diagnostic work-up

2. Therapy

3. Patient education

D. Progress notes

1. Written by all members of the health care team

2. Systematic format is SOAP (acronym)

a. Subjective data

b. Objective data

c. Assessment

d. Planning

IV. Six Parts of a Traditional Client Record

A. Admission sheet - contains specific identifying data

B. Face sheet - front sheet of chart frequently used to list client allergies

C. Doctor's order sheet - written record of physician's orders

D. History sheet - record of the client's health history written by the physician

E. Nurses' notes - record of nursing interventions; assessments and evaluation of nursing intervention effectiveness; appropriate information to include:

1. Assessment of client by various nursing personnel

2. Nursing interventions ordered by physician

        3. Nursing interventions

        4. Evaluation of effectiveness of nursing interventions

        5. Specific measures carried out by physician

        6. Visits by members of the health team

    F. Special reports and records

V. Advantages of the Kardex Record

    A. Significant data quickly accessible to members of the health team

    B. Index-type file (portable)

    C. Written in pencil - changed frequently to be up-to-date

VI. Guidelines for Recording (HO 1)

    A. Brevity

        1. Keep record of pertinent data brief.

        2. Use correct terms and acceptable abbreviations and symbols (consult textbook).

    B. Accuracy

        1. Data must be accurate and specific.

        2. Omission of significant data is considered inaccurate.

    C. Legibility - record in ink for permanent record, necessary for photocopying

    D. Correct spelling - important for accuracy

    E. Differentiating between observation and interpretation - record observations accurately and distinguish them from interpretations

    F. Consecutive lines

        1. Records are chronological and made on consecutive lines.

        2. Draw straight line behind entry which does not fill entire line to prevent inserts.

        3. Begin each thought with a capital letter and end with a period.

    G. Signature - legal signature and abbreviation of title

    H. Where and when to chart - done in accord with agency policy

VII. Legal Considerations in Recording

A. Client records can be admitted as evidence in court

B. Never erase - errors should have line drawn through with word "error," initials of person charting, and date.

C. Never alter charting - once written in chart it is permanent

D. Do not leave blanks - draw straight line from end of statement to edge of paper

E. Chart only data. Do not chart judgments or conclusions.

F. Be specific. Do not use general terms.

G. Chart frequently - legally assumed that if no charting occurs, the client was neither seen nor provided care

H. Use standardized abbreviations to eliminate possibility of misinterpretation.

I. Nurses must practice within the guidelines established in their individual state's Nurse Practice Act

J. Document safety precautions which protect the client (side rails).

K. Document observations taken to prevent complications (postoperative bleeding checks).

VIII. Summary and Conclusion

A. Reasons for records

B. Definition of terms

C. Problem oriented records

D. Six parts of a traditional client record

E. Advantages of Kardex record

F. Guidelines for recording

G. Legal considerations in recording

LESSON PLAN: 5

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATION

INTERACTION ITEMS:

1. What is required in writing thorough nurse's notes?
2. What are the aspects of charting?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Discuss general areas with specific content for each (HO 1) to be included in charting nurses' notes.

2. Give an example of client assessment and have students "chart" nurses' notes from that assessment.

LESSON PLAN: 5

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATION

EVALUATION ITEMS

1. Identify two reasons for keeping client records.

   a.

   b.

2. Match the following terms to their correct definitions:

______	a.	Audit	1.	Record keeping; client-centered, problem-solving, approach
______	b.	Data base	2.	Monitor nursing care
______	c.	Peer review	3.	Initial admission information
______	d.	Problem Oriented Record	4.	Record review for quality of care

3. Identify two parts of a traditional client record.

   a.

   b.

4. List three advantages of the Kardex record.

   a.

   b.

   c.

5. Following the guidelines for charting, you must interpret your observations. True or False? (Circle one.)

6. Nurses practice within the guidelines of the Nurse Practice Act. There is one nurse practice act, which is universally accepted by all nurses in the United States. True or False? (Circle one.)

7. List the specific content you would chart from your observation of a client's skin (eight items).

   a.

   b.

   c.

   d.

   e.

   f.

   g.

   h.

LESSON PLAN: 5

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATION

ANSWERS TO EVALUATION ITEMS

1. Reasons for records - any two of the following:
   a. Communication - to convey meaningful information among health team members
   b. Legal documentation - admissible in court as evidence; property of the agency, but client has a right to information in the record
   c. Research - information provides tool for future research into disease, drugs, treatments, etc.
   d. Statistics - help anticipate and plan for future needs
   e. Education - students from all areas of the health discipline utilize records as an educational tool
   f. Audit - monitor quality of care

2. a. 4
   b. 3
   c. 2
   d 1

3. Six parts of a traditional client record - any two of the following:
   a. Admission sheet
   b. Face sheet
   c. Doctor's order sheet
   d. History sheet
   e. Nurses' notes
   f. Special reports and records

4. Three advantages of the Kardex record:
   a. Significant data quickly accessible to members of the health team
   b. Index-type file (portable)
   c. Written in pencil - changed frequently to be up-to-date

5. False

6. False

7. a. Color
   b. Temperature
   c. Perspiration
   d. Rash
   e. Pruritis
   f. Pressure areas
   g. Laceration
   h. Ecchymosis

CHARTING GUIDELINES

I. General Areas to Consider
    A. Nutrition
    B. Elimination
    C. Subjective/objective observations
    D. Nursing care
    E. Appointments
    F. Physician's visits
    G. Medication
        1. Administration on medication sheet
        2. Response on nurse's notes

II. Specific areas to consider
    A. Nutrition
        1. Diet
            a. Amount client ate
            b. Likes and dislikes
            c. Compliance with diet
            d. Tolerance
            e. Appetite
            f. Nausea and vomiting
            g. Amount of help required when eating
        2. Fluids - amount taken
    B. Elimination
        1. Bowel
            a. Amount

- b. Color
- c. Consistency
- d. Frequency
- e. Odor
- f. Time
- g. Incontinence
- h. Note if specimen sent to lab
- i. Unusual characteristics

2. Urine
    - a. Amount
    - b. Color
    - c. Odor
    - d. Concentration
    - e. Time
    - f. Incontinence
    - g. Note if specimen sent to lab
    - h. Unusual characteristics

C. Subjective/objective observations

1. Skin
    - a. Color
    - b. Temperature
    - c. Perspiration
    - d. Rash
    - e. Pruritis
    - f. Pressure areas
    - g. Lacerations
    - h. Ecchymosis

2. Mouth
    a. Teeth
    b. Gums
    c. Mucous membrane
    d. Tongue
    e. Special mouth care
        (1) Procedure
        (2) Client response
    f. Odor of breath
3. Hair
    a. Condition
    b. Special care
        (1) Procedure
        (2) Client response
4. Nails
    a. Condition
    b. Special care (especially diabetic client)
        (1) Procedure
        (2) Client response
5. Eyes
    a. Pupils
    b. Conjunctiva
    c. Prosthesis
    d. Eyelids
    e. Vision
    f. General condition

6. Ears
    a. Condition
    b. Drainage
    c. Pruritus
    d. Hearing
7. Nose
    a. Condition
    b. Coryza
    c. Breathing (through nose or mouth)
8. Respiratory system
    a. Rate
    b. Depth
    c. Type
    d. Position
    e. Muscles
9. Circulatory system
    a. Skin color
    b. Skin temperature
    c. Pulse (rate, strength, location)
    d. Blood pressure
    e. Venous stasis
    f. Indications of thrombophlebitis
10. Nervous system
    a. Sensation (location - description)
    b. Motor function (paralysis, spasticity)
    c. Neuromuscular function (coordination, speech)
    d. Mental alertness

11. Gastrointestinal system
    - a. Distention
    - b. Pain
    - c. Nausea - vomiting (describe)
    - d. Bleeding
    - e. Digestion
12. Pain
    - a. Location
    - b. Duration
    - c. Intensity
    - d. Recurrence
    - e. Precipitating factors
    - f. Action taken - client response
    - g. Objective signs (position, expression)
13. Drainage
    - a. Amount
    - b. Color
    - c. Odor
    - d. Character
    - e. Location
        - 1. Dressing - appearance
        - 2. Incision - appearance
14. Behavior of client
    - a. Attitude
    - b. Feelings
    - c. Reactions
    - d. Mood - mood changes

    - e. Unusual behavior

D. Nursing Care - Treatment/Activity

  1. What was done
  2. Time
  3. Client response
  4. Equipment used (if appropriate)
  5. Nurse's name
  6. Ambulation (time, duration, response)

E. Appointments

  1. Place
  2. Time (departed, returned)
  3. Mode of transportation

F. Physician's visits

  1. Time
  2. Name of physician

G. Medication

  1. Name of drug
  2. Dosage
  3. Route
  4. Time
  5. Untoward effects or reactions
  6. Reason for giving if p.r.n.
  7. Reason for omission
  8. Initial

LESSON PLAN: 6

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATION

SCOPE OF UNIT:

This unit is designed to teach the student essential facts about the communication process and effective and ineffective methods of communicating with clients and with other members of the health care team. The teaching/learning process will be included to guide the student's development of a client teaching plan. Process recordings will be used to assess and evaluate student-client interactions. The unit will help the student develop a beginning understanding of the documentation process on the professional level in relation to client records.

INFORMATION TOPIC: X OR DEMONSTRATION:

DOCUMENTATION - REPORTING
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Discuss the importance of clear communication among health team members to facilitate process of client care.
2. Identify six types of verbal communication
3. Identify three requirements of reports.
4. List methods which can be used to give change of shift reports. Give advantages and disadvantages of each method.
5. List seven elements which produce a skillful verbal report.
6. Identify guidelines for verbal report.
7. Develop format for verbal report.
8. Describe skillful receiving of verbal report.
9. Describe how to take physician's telephone orders.
10. Describe how to take physician's verbal orders.
11. Describe a team conference including identification of participants and purpose.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

INFORMATIONAL ASSIGNMENT: (Student)

Kozier, Barbara and Glenora Erb. Fundamentals of Nursing: Concepts and Procedures. 2nd ed. Menlo Park, CA: Addison-Wesley Co. 1983. pp. 425-444.

Wolff, L., et al. Fundamentals of Nursing. 7th ed. New York: J.B. Lippincott Co. 1983. pp. 240-250.

REFERENCES: (Instructor's Additional Information)

Atkinson, Leslie D. and Mary Ellen Murray. Fundamentals of Nursing. New York: MacMillan Publishing Co., Inc. 1985.

Kemp, Brenda and Adele Pillitteri. Fundamentals of Nursing. Boston: Little, Brown & Co. 1984.

Sorensen, Karen and Joan Luckmann. Basic Nursing. Philadelphia: W.B. Saunders Co. 1979.

Sundeen, et al. Nurse-Client Interaction. St. Louis: C.V. Mosby Co. 1976.

Wilson, Holly S. and Kneisl. Psychiatric Nursing. 2nd ed. Menlo Park, CA: Addison-Wesley Co. 1983.

INTRODUCTION:

This lesson concerns the importance of clear communication among health team members and guidelines for skillful reporting.

LESSON PLAN: 6

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATION

INFORMATION TOPIC: II-6

OUTLINE: (Key Points)

I. Importance of Clear Communication Among Health Team Members to Process of Client Care

  A. Provides basis for plan of comprehensive client care

  B. Avoids duplication

  C. Shares information

  D. Everyone shares same goal for client

II. Types of Verbal Communication

  A. Change of shift report

  B. Giving verbal report

  C. Receiving verbal report

  D. Physician's telephone orders

  E. Physician's verbal orders

  F. Team conferences

III. Requirements of Reports

  A. Factual

  B. Concise

  C. Descriptive

IV. Methods Used for Change of Shift Reports

  A. Tape-recording

    1. Advantages

      a. Clarification through editing

      b. Repeated for clarity

        - c. Repeated for late arrivals
    - 2. Disadvantage - does not allow for questions
- B. Traditional report by charge nurse
    - 1. Advantage - questions can be answered
    - 2. Disadvantage - secondhand information
- C. Traditional report by primary care giver
    - 1. Advantage
        - a. Maximum opportunity to ask questions
        - b. Continuity of plan of care
    - 2. Disadvantage - total information fragmented among staff
- D. Walking rounds
    - 1. Advantage
        - a. Given at bedside from care giver to oncoming nurse
        - b. Patient introduced to new care giver
        - c. Patient can add to information that is omitted
        - d. Enhances client trust
    - 2. Disadvantage
        - a. Time consuming
        - b. Some staff uncomfortable talking in front of client

V. Elements Which Produce a Skillful Verbal Report

- A. Conciseness
- B. To the point
- C. Brief
- D. Contains all necessary information
- E. Voice clear
- F. Voice loud enough to be heard
- G. Voice slow enough to allow note taking

VI. Guidelines for Verbal Report

- A. Establish format
  - 1. Enhances listener readiness
  - 2. Information to include
    - a. Name of client
    - b. Medical diagnosis
    - c. Chief complaint
    - d. Physician
    - e. Diagnostic procedures of the day
    - f. Client's condition
    - g. Response to medication
    - h. Response to treatment
    - i. Observations or treatments to be completed on next shift
- B. Logical order, sequence for several clients by rooms
- C. SOAP organization for one client
  - 1. S - subjective: complaints
  - 2. O - objective: fever 102 - 6°F
  - 3. A - assessment: possible wound infection
  - 4. P - planning: Aspirin gr X q 4h for fever, culture wound

    Aspirin gr X given at 1 p.m., culture sent to lab
- D. Confidentiality respected - report only data necessary for client care
- E. Be specific, exact, brief; include all essential information.

VII. Skillful Receiving of a Verbal Report

- A. Be aware of general condition of all clients.
- B. Identify client assignment.
- C. Take notes regarding assigned clients on worksheet.
- D. Check Kardex to complete worksheet.

- E. Organize and plan client care using verbal report and Kardex.

VIII. Physician's Telephone Orders

- A. Student nurses are not authorized to take telephone orders.
- B. The registered nurse will:
  1. Record order on order sheet.
  2. Note "telephone order of Dr. ....."
  3. Sign name.
  4. Read order back to verify accuracy.
  5. Carry out order.
- C. Physician must sign order within 24 hrs.

IX. Physician's Verbal Orders

- A. Ask physician to write orders.
- B. In emergency, rapidly-given orders are carried out. Times and essential information noted and documented after emergency by physician and nurse.

X. Team Conference

- A. Participants
  1. Head nurse and/or team leader
  2. Team members
     - a. Registered nurses
     - b. Licensed practical nurses
  3. Patient (if appropriate)
  4. Dietary (if appropriate)
  5. Physical therapy (if appropriate)
  6. Other appropriate health team members
- B. Purpose
  1. To discuss and plan client care
  2. Problem-solve by working together to discover solutions
- C. Format

    1. Brief summary of client history
    2. Current problems identified
    3. Suggest alternative approaches
    4. Decide implementation

XI. Summary and Conclusion

  A. Importance of clear communication among health team members to process of client care

  B. Types of verbal communication

  C. Requirements of reports

  D. Methods used for change of shift reports

  E. Elements which produce a skillful verbal report

  F. Guidelines for verbal report

  G. Skillful receiving of a verbal report

  H. Physician's telephone orders

  I. Physician's verbal orders

  J. Team conference

LESSON PLAN: 6

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATION

INTERACTION ITEMS:

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Discuss change of shift report guidelines, including important information to relay and why exclusion of gossip from report is desirable.
2. Discuss the importance of clear communication among health team members.
3. Describe how you would organize and give a change of shift report. Role-play change of shift report, utilizing the format you developed.

LESSON PLAN: 6

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATION

EVALUATION ITEMS

1. Identify two types of verbal communication.

   a.

   b.

2. Identify three requirements of reports.

   a.

   b.

   c.

3. List two methods for change of shift report and identify one advantage and one disadvantage for those methods.

   a.

   b.

4. List three of the seven elements which produce a skillful verbal report.

   a.

   b.

   c.

5. Skillful receiving of verbal report includes taking notes and making a worksheet. True or False ? (Circle one.)

6. Physician's telephone orders must be signed by the physician in 12 hours. True or False? (Circle one.)

7. The best way to receive verbal orders from a physician is to write them down on the doctor's order sheet immediately. True or False (Circle one.)

8. Describe the two-fold purpose of a team conference.

LESSON PLAN: 6

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATION

ANSWERS TO EVALUATION ITEMS

1. Types of verbal communication - any two of the following:
    a. Change of shift report
    b. Giving verbal report
    c. Receiving verbal report
    d. Physician's telephone orders
    e. Physician's verbal orders
    f. Team conferences

2. Three requirements of reports
    a. Factual
    b. Concise
    c. Descriptive

3. Methods used for change of shift reports - any two of the following, (including one advantage and one disadvantage for each method listed):
    a. Tape-recording
        (1) Advantages
            (a) Clarification through editing
            (b) Repeated for clarity
            (c) Repeated for late arrivals
        (2) Disadvantage - does not allow for questions
    b. Traditional report by charge nurse
        (1) Advantage - questions can be answered
        (2) Disadvantage - secondhand information
    c. Traditional report by primary care giver
        (1) Advantage
            (a) Maximum opportunity to ask questions
            (b) Continuity of plan of care
        (2) Disadvantage - total information fragmented among staff
    d. Walking rounds
        (1) Advantage
            (a) Given at bedside from care giver to oncoming nurse
            (b) Client introduced to new care giver
            (c) Client can add to information that is omitted
            (d) Enhances patient trust
        (2) Disadvantage
            (a) Time consuming
            (b) Some staff uncomfortable talking in front of patient

4. Elements which produce a skillful verbal report - any three of the following:
    a. Conciseness
    b. To the point
    c. Brief
    d. Contains all necessary information

    e. Voice clear
    f. Voice loud enough to be heard
    g. Voice slow enough to allow note taking

5. True
6. False
7. False
8. The purpose of a team conference is to discuss and plan patient care and to problem-solve by working together to discover solutions.

LESSON PLAN: 7

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATION

SCOPE OF UNIT:

This unit is designed to teach the student essential facts about the communication process and effective and ineffective methods of communicating with clients and with other members of the health care team. The teaching/learning process will be included to guide the student's development of a client teaching plan. Process recordings will be used to assess and evaluate student-client interactions. The unit will help the student develop a beginning understanding of the documentation process on the professional level in relation to client records.

INFORMATION TOPIC: X OR DEMONSTRATION:

CLIENT TEACHING/LEARNING
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match the following terms to correct definitions:
    a. Teaching
    b. Learning
    c. Compliance
    d. Motivation
    e. Learning need
    f. Feedback
2. Identify principles that aid learning.
3. Identify factors that affect learning.
4. Identify principles that aid teaching.
5. Utilize nursing process to meet learning needs:
    A. Identify steps to assess learner needs.
    B. Describe steps to plan teaching.

C. Identify methods of implementing teaching plan.

D. Identify evaluation process.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Trainex 572 - Nurse is a Teacher: The Nursing Role in Teaching
2. Trainex 573 - Nurse is a Teacher: Principles of Learning
3. Trainex 574 - Nurse is a Teacher: Principles of Teaching
4. Trainex 575 - Nurse is a Teacher: Teaching Methods
5. Trainex 576 - Nurse is a Teacher: Teaching and the Nursing Process

INFORMATIONAL ASSIGNMENT: (Student)

Kozier, Barbara and Glenora Erb. Fundamentals of Nursing: Concepts and Procedures. 2nd ed. Menlo Park, CA: Addison-Wesley Co. 1983. pp. 410-423.

Wolff, L., et al. Fundamentals of Nursing. 7th ed. New York: J.B. Lippincott Co. 1983. pp. 254-268.

REFERENCES: (Instructor's Additional Information)

Atkinson, Leslie D. and Mary Ellen Murray. Fundamentals of Nursing. New York: MacMillan Publishing Co., Inc. 1985.

Kemp, Brenda and Adele Pillitteri. Fundamentals of Nursing. Boston: Little, Brown & Co. 1984.

Sorensen, Karen and Joan Luckmann. Basic Nursing. Philadelphia: W.B. Saunders Co. 1979.

Sundeen, et al. Nurse-Client Interaction. St. Louis: C.V. Mosby Co. 1976.

Wilson, Holly S. and Kneisl. Psychiatric Nursing. 2nd ed. Menlo Park, CA: Addison-Wesley Co. 1983.

INTRODUCTION:

This lesson concerns the importance of knowing teaching/learning principles and how they are related to client teaching.

LESSON PLAN: 7

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATION

INFORMATION TOPIC: II-7

OUTLINE: (Key Points)

I. Definitions

  A. Teaching - activities to produce learning

  B. Learning - permanent change in behavior

  C. Compliance - recognize/accept need to learn

  D. Motivation - desire

  E. Learning need - difference perceived between real and desired situation

  F. Feedback - information concerning performance related to goal

II. Principles That Aid Learning

  A. Interest and motivation increase when learning is relevant and need is perceived.

  B. Understanding increases when movement is from simple to complex.

  C. Anxiety

    1. High level impairs learning.

    2. Low level decreases motivation.

    3. Sufficient level motivates maximum learning.

  D. Patient perceives need and sees information as a way to meet that need.

  E. Active involvement - makes learning meaningful

  F. Successful learning - reduces failure anxiety, increases confidence

  G. Feedback

    1. Positive

      a. Desired behavior praised

      b. Constructive criticism offered

        - c. Alternatives suggested
    - 2. Negative
        - a. Ridicule
        - b. Anger
        - c. Sarcasm
- H. Physical, emotional, and mental status affect type, amount, and rate of learning.
- I. Retention is better if learning is spaced at intervals, not concentrated.
- J. Retention is better if learning can be applied.
- K. Retention is better if learning is reinforced positively.
- L. Learning involving change in self-concept perceived as threat, is resisted.
- M. Information related to prior knowledge easier to learn.
- N. Rewarding experiences motivate learning.
- O. Practice with positive feedback improves performance.

III. Factors That Affect Learning

- A. Anxiety level
    - 1. High - decreases learning
    - 2. Mild - enhances learning
- B. Physical status - fatigue, hunger
- C. Age - limitations depend on development
- D. Motivation - greatest if need recognized
- E. Communication skills - ability to perceive, understand, and express thoughts, feelings to others
- F. Senses - seeing difficulty, hearing difficulty
- G. Education experience - comprehension or language barriers
- H. Physical environment - heat, light, noise
- I. Timing
    - 1. Time

        2. Length of learning session
        3. Intervals between learning sessions
    J. Teaching methods/aids - depends on individual preference
    K. Content - relate to needs

IV. Principles That Aid Teaching
    A. Activity must meet objective
    B. Teacher-student rapport essential
    C. Previous learning facilitates acquisition of new skills
    D. Communicate clearly

V. Using Nursing Process Format to Teach
    A. Assessment of Learning Needs
        1. Obtain data - from client, family, and client record
            a. Perception of needs - significant
            b. Problems of concern - related to home life
            c. Employment
            d. Financial resources
            e. Recent data from chart
            f. Possible outcomes
            g. Adjustment to illness
        2. Identify learning needs
            a. Needs recognized by client
            b. Needs client is not aware of
        3. Determine client's readiness and ability to learn
            a. Age/developmental status
            b. Educational and socioeconomic status
            c. Physical status
            d. Emotional status

        - e. Stage of illness - if illness has been accepted, client will learn more effectively
        - f. Motivation
        - g. Anxiety level

B. Planning of teaching - done by nurse, client and family

    1. Set goals - intended long-term, general outcome
    2. Set objectives - intended short-term, specific outcome
        - a. Performance - describe behavior of client after mastery of objective
        - b. Conditions - identify conditions under which behavior is acceptable
        - c. Criteria - set standards for acceptable behavior (speed, quality, accuracy)
    3. Set priorities - a combination of client-perceived needs and nurse's judgment
    4. Plan content - write plan in narrative or outline format
    5. Select method of teaching
        - a. Relate to client needs
        - b. Relate to type of learning
            1. Psychomotor learning - learn skills
            2. Affective learning - change attitudes
            3. Cognitive learning - acquire knowledge
    6. Methods applicable to psychomotor, affective, and cognitive learning
        - a. Explanation
        - b. Discussion
            1. One-to-one
            2. Group
        - c. Question and answer session
        - d. Demonstration

        - e. Practice
        - f. Books
        - g. A-V material
        - h. Role playing
  - C. Implementation of teaching plan
    - 1. Conduct session using planned strategy.
    - 2. Revise plan if necessary.
    - 3. Choose environment conducive to learning.
    - 4. Choose time client is most receptive.
    - 5. Choose method appropriate to subject and client.
  - D. Evaluation of teaching and learning is an ongoing assessment.
    - 1. Feedback - tells learner how he/she is progressing
    - 2. Reinforce or correct behavior
    - 3. Evaluate teaching
      - a. Questions, comments
      - b. Answers to direct question
      - c. Demonstration of skill
      - d. Observation of family
      - e. Declaration of understanding
- V. Summary and Conclusion
  - A. Definitions
  - B. Principles that aid learning
  - C. Factors that affect learning
  - D. Principles that aid teaching
  - E. Using nursing process to teach

LESSON PLAN: 7

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATION

INTERACTION ITEMS:

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Select a client with a knowledge deficit. Design a teaching plan following the format used by your school with assistance from client and family (if appropriate). Implement plan.
2. Discuss individual learning experiences related to principles of learning and principles of teaching.
3. Using the nursing process, develop a teaching plan for a patient with instructor approval following format of your school's nursing program.

LESSON PLAN: 7

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATION

EVALUATION ITEMS

Definitions: Match the following terms to correct definitions.

_____ 1. Teaching

_____ 2. Learning

_____ 3. Compliance

_____ 4. Motivation

_____ 5. Learning need

_____ 6. Feedback

a. Difference perceived between real and desired situation

b. Desire

c. Recognize and accept need to learn

d. Activities to produce learning

e. Information concerning performance related to goal

f. Permanent change in behavior

7. Identify three principles that aid learning.

    a.

    b.

    c.

8. Identify two factors that affect learning.

    a.

    b.

9. Identify two principles that aid teaching.

    a.

    b.

LESSON PLAN: 7

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT II COMMUNICATION

ANSWERS TO EVALUATION ITEMS

1. d
2. f
3. c
4. b
5. a
6. e

7. Principles that aid learning - any three of the following:
   a. Interest and motivation increase when learning is relevant and need is perceived.
   b. Understanding increases when movement is from simple to complex.
   c. Anxiety
      (1) High level impairs learning.
      (2) Low level decreases motivation.
      (3) Sufficient level motivates maximum learning.
   d. Patient perceives need and sees information as a way to meet that need.
   e. Active involvement - makes learning meaningful
   f. Successful learning - reduces failure anxiety, increases confidence
   g. Feedback
      (1) Positive
         (a) Desired behavior praised
         (b) Constructive criticism offered
         (c) Alternatives suggested
      (2) Negative
         (a) Ridicule
         (b) Anger
         (c) Sarcasm
   h. Physical, emotional, and mental status affect type, amount, and rate of learning.
   i. Retention is better if learning is spaced at intervals, not concentrated.
   j. Retention is better if learning can be applied.
   k. Retention is better if learning is reinforced positively.
   l. Learning involving change in self-concept perceived as threat, is resisted.
   m. Information related to prior knowledge easier to learn.
   n. Rewarding experiences motivate learning.
   o. Practice with positive feedback improves performance.

8. Factors that affect learning - any two of the following:
   a. Anxiety level
      1. High - decreases learning
      2. Mild - enhances learning
   b. Physical status - fatigue, hunger
   c. Age - limitations depend on development
   d. Motivation - greatest if need recognized
   e. Communication skills - ability to perceive, understand, and express thoughts, feelings to others
   f. Senses - seeing difficulty, hearing difficulty
   g. Education experience - comprehension or language barriers
   h. Physical environment - heat, light, noise
   i. Timing
      1. Time
      2. Length of learning session
      3. Intervals between learning sessions
   j. Teaching methods/aids - depends on individual preference
   k. Content - relate to needs

9. Principle that aid teaching - any two of the following
   a. Activity must meet objective
   b. Teacher-student rapport essential
   c. Previous learning facilities acquisition of new skills
   d. Communicate clearly

LESSON PLAN: I

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT III NURSING PROCESS

SCOPE OF UNIT:

This unit defines, explains, and illustrates the basic elements of the nursing process and relates the importance of nursing process as the basis of providing nursing care for clients. Comparisons are drawn between the process and the clinical unit nursing care plan.

INFORMATION TOPIC: X OR DEMONSTRATION:

AN OVERVIEW OF THE NURSING PROCESS
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Define nursing process.
2. Compare the nursing process with the scientific method.
3. Identify seven essential elements of nursing process.
4. List the phases of nursing process in proper sequence.
5. Explain the importance of involving the client in all phases of nursing process.
6. Identify the skills necessary for nursing process.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. TM I: The Circular and Dynamic Nature of the Nursing Process

INFORMATIONAL ASSIGNMENT: (Student)

Kozier, B. and G. Erb. Fundamentals of Nursing: Concepts and Procedures. Menlo Park, CA: Addison-Wesley Publishing Co., 1983. pp. 116-121.

Wolff, L., et al. Fundamentals of Nursing. 7th ed. New York: J.B. Lippincott Co. 1983. pp. 199-201.

REFERENCES: (Instructor's Additional Information)

Atkinson, L.D. and M.E. Murray. Understanding The Nursing Process. New York: MacMillan Publishing Company, Inc., 1983.

Kemp, Brenda and Adele Pillitteri. Fundamentals of Nursing. Boston: Little, Brown and Co., 1984.

Murray, Malinda. Fundamentals of Nursing. Englewood Cliffs, NJ: Prentice Hall, Inc., 1980.

Yura, H. and M.B. Walsh. The Nursing Process. New York: Appleton, Century-Crofts, 1981.

INTRODUCTION:

The nursing process is central to all nursing actions. It is a designated series of actions designed to achieve the goal of nursing, which is client wellness. Nursing process is a relatively new term that describes the five steps that are essential to nursing care. Nurses have always identified client problems and worked to solve these problems. The process used to arrive at the identification of these problems and to determine plausible solutions should not be haphazard or based on intuition. Nursing process encourages a scientific approach since it utilizes a systematic, organized method for identifying and treating client problems. Let's look at the process as a whole and then we will study each component.

LESSON PLAN: 1

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT III NURSING PROCESS

INFORMATION TOPIC: III-1

OUTLINE: (Key Points)

I. Definitions

  A. Process - a series of actions leading to a specific result

  B. Nursing process - a systematic method for analyzing client problems, determining how to solve them, carrying out a plan of action, and evaluating its effectiveness

II. Essential Elements of Nursing Process

  A. Based on scientific principles

  B. Planned

  C. Client centered

  D. Problem oriented - similar to scientific method

  E. Goal directed

  F. Holistic

  G. Applicable in any setting

III. Phases of Nursing Process [illegible]

  A. Assessment - act of reviewing a situation in order to identify a client's characteristics, needs, and problems

  B. Nursing diagnosis - identification of the client's response to his/her situation

  C. Planning - involves goal setting and designing methods for the resolution of client problems

  D. Implementation - actions; the plan is carried out

  E. Evaluation - the results of the nursing actions are evaluated

IV. Involvement of Client in Process

  A. Necessary if nursing actions are to be effective

B. The nurse needs to know the client's feelings about the therapy and whether or not the client will comply with nursing actions.

V. Skills Necessary for Nursing Process

A. Intellectual skills

1. Critical thinking - once the nurse has gathered data, he/she uses critical thinking to start analyzing the data to see what it means; best to consider all alternatives

2. Problem-solving - the nurse uses this skill to define problems based on the interpretations made by critical thinking

3. Decision-making - these skills are used to decide a particular course of action

B. Interpersonal skills - skills that help the nurse relate to other people

1. Self-knowledge - the better the nurse understands self, the more insight she/he will bring to client situations

2. Self-image - the way the nurse sees herself/himself

3. Communication - therapuetic, not social; helps the client to make own decisions and come to own conclusions

C. Technical skills - necessary for effective nursing care; involves the acquisition of psychomotor skills

VI. Summary and Conclusion

A. Definition of nursing process

B. Essential elements of nursing process

C. Phases of nursing process

D. Involvement of client in process

E. Skills necessary for nursing process

LESSON PLAN: I

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT III NURSING PROCESS

INTERACTION ITEMS:

1. What are some of the courses you have taken in the past that used the scientific method of problem solving?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. On a sheet of paper draw the phases of the nursing process in the circular pattern.
2. In your own words explain the term "humanistic approach" as it relates to the nursing process.
3. Compare and contrast the scientific method with nursing process.

LESSON PLAN: I

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT III NURSING PROCESS

EVALUATION ITEMS

Directions: Place the letter of the phrase which correctly answers the question in the space provided.

_____ 1. The nursing process is based on:

- a. Biomedical engineering
- b. Scientific principles
- c. Medical diagnoses
- d. Problem-oriented medical records

_____ 2. Other essential elements of the nursing process include:

- a. Problem orientation
- b. Goal-directed
- c. Client-centered
- d. Holistic approach
- e. All of the above

_____ 3. Several intellectual skills are required for the nurse to be effective. Which intellectual skill is used when a nurse chooses a specific course of action?

- a. Self-image
- b. Critical thinking
- c. Communication
- d. Decision-making

_____ 4. In addition to intellectual skills, the nurse must also develop skills that help her/him to relate to other people. These skills are known as _______________ skills.

- a. Problem-solving
- b. Critical thinking
- c. Interpersonal
- d. Technical

5. In your own words explain the importance of involving the client in each phase of nursing process.

Directions: The following diagram denotes the circular nature of nursing process. Beside each numbered blank write in the step that is indicated. Number 6 represents the first phase.

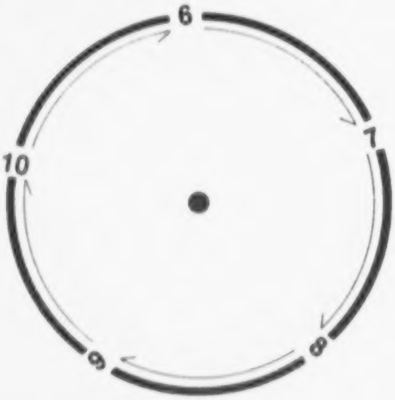
6. ______________________

7. ______________________

8. ______________________

9. ______________________

10. ______________________



11. Define nursing process in your own words.

12. Compare nursing process with the scientific method.

LESSON PLAN: I

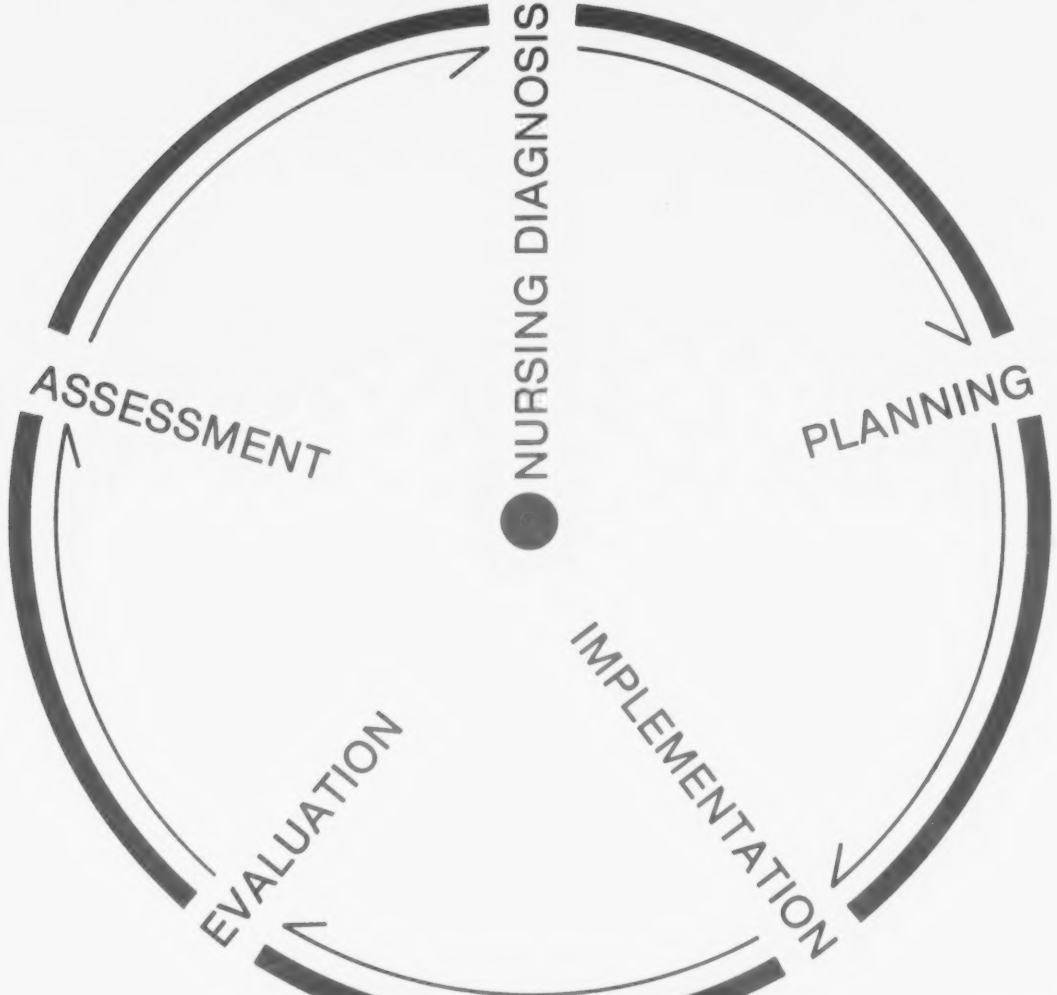
COURSE TITLE: FUNDAMENTALS OF NURSING CORE CURRICULUM

UNIT III NURSING PROCESS

ANSWERS TO EVALUATION ITEMS

1. b
2. e
3. d
4. c
5. Answers will vary.
6. Assessment
7. Nursing diagnosis
8. Planning
9. Implementation
10. Evaluation
11. Answers will vary.
12. Answers will vary.

The Circular and Dynamic Nature of the Nursing Process


NURSING DIAGNOSIS
PLANNING
IMPLEMENTATION
EVALUATION
ASSESSMENT

LESSON PLAN: 2

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT III NURSING PROCESS

SCOPE OF UNIT:

This unit defines, explains, and illustrates the basic elements of the nursing process and relates the importance of nursing process as the basis of providing nursing care for clients. Comparisons are drawn between the process and the clinical unit nursing care plan.

INFORMATION TOPIC: X OR DEMONSTRATION:

ASSESSMENT PHASE
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Define assessment.
2. Distinguish between primary and secondary sources of data for a nursing assessment.
3. Relate various factors that influence the client's ability to provide accurate assessment information.
4. Identify methods of collecting data during the assessment phase of nursing process.
5. Describe ways to organize data in order to make it more useful for planning nursing care.
6. Identify the types of data collected during the assessment phase of nursing process.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. The participating school's philosophy

INFORMATIONAL ASSIGNMENT: (Student)

Kozier, B. and G. Erb. Fundamentals of Nursing: Concepts And Procedures. Menlo Park, CA: Addison-Wesley Publishing Co., 1983. pp. 121-133.

Wolff, L., et al. Fundamentals of Nursing. 7th ed. New York: J.B. Lippincott Co. 1983. pp. 201-208.

REFERENCES: (Instructor's Additional Information)

Atkinson, L.D. and M.E. Murray. Understanding The Nursing Process. New York: MacMillan Publishing Company, Inc., 1983.

Kemp, Brenda and Adele Pillitteri. Fundamentals of Nursing. Boston: Little, Brown and Co., 1984.

Murray, Malinda. Fundamentals of Nursing. Englewood Cliffs, NJ: Prentice Hall, Inc., 1980.

Yura, H. and M.B. Walsh. The Nursing Process. New York: Appleton, Century-Crofts, 1981.

INTRODUCTION:

In the first lesson of this unit we explored the nursing process in general. Now we will proceed to study the components of nursing process, the first of which is assessment. Assessment is a skill that all of us have developed to some degree and use rather frequently. Before making any decision we usually attempt to assess the particular situation as accurately as possible so that we will make the proper decision. As nurses, the actions we take to help clients are based on our assessments. It is obvious then, how important the assessment phase is to effective nursing care.

LESSON PLAN: 2

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT III NURSING PROCESS

INFORMATION TOPIC: III-2

OUTLINE: (Key Points)

I. Definition of Assessment - systematic method of reviewing a situation in order to identify the client's characteristics, needs, and problems

II. Steps of Assessment

  A. Data collection - collect data about client's physical health, mental health, social circumstances, family and community life

    1. Sources of data

      a. Primary source - client

        (1) Factors influencing client information

          (a) Usual response to illness

          (b) Ability/inability to communicate

          (c) Negative feeling related to illness (embarrassment, fear of criticism, fear of employment being jeopardized)

      b. Secondary sources

        (1) Significant others

        (2) Health care team members

        (3) Records

        (4) Laboratory and other diagnostic procedures

        (5) Literature - provides data about typical response to this condition

    2. Types of data

      a. Subjective - information from client, record as a quote whenever possible.

      b. Objective/factual information - data that can be seen, heard, felt, smelled, or measured in some way

c. Validate each type of data with the other if possible

EXAMPLE: Client says "I feel hot" - Take temperature

3. Methods of data collection

    a. Nursing history - covered in Lesson III-3

    b. Observation - gathering of data through the use of your senses with an understanding of what you are observing

    c. Physical assessment

        (1) Inspection

            (a) Visual examination for detection of significant physical features

            (b) May be the most important technique of the nursing physical assessment

        (2) Palpation - determination of the characteristics of organs or tissues through the use of tactile senses

            (a) Tips of fingers: Used for fine tactile discrimination such as texture of skin

            (b) Dorsa of hands and fingers: Used for temperature sensing

            (c) Palmar aspects of fingers: Sensitive to vibration

            (d) Grasping of fingers: Used to determine position and consistency

            (e) Ballottement: Pressure exerted on organ and then rapidly released to assess rebound pain

        (3) Percussion - striking or tapping of the body surface to produce sounds that reflect the position, size, and density of underlying structures

        (4) Auscultation - listening to sounds produced by various organs (heart, lungs, abdomen)

    d. Psychosocial assessment

        (1) General appearance

            (a) Personal hygiene

            (b) Appropriateness of dress

- (2) Motor activity
    - (a) Hyperactivity (restlessness, agitation)
    - (b) Hypoactivity (slow movements)
- (3) Facial expressions - appropriate to spoken words?
- (4) Speech patterns
    - (a) Coherence
    - (b) Inflection
    - (c) Organization
- (5) General mood
    - (a) Anger
    - (b) Fear
    - (c) Euphoria
- (6) Memory
    - (a) Recent past
    - (b) Remote past
- (7) Orientation
    - (a) Time
    - (b) Place
    - (c) Person
- (8) Thought content
    - (a) Types of things client thinks about
    - (b) Any disturbing thoughts related to this illness
- (9) Thought processes
    - (a) Logical/illogical
    - (b) Coherent/incoherent

e. Consultation

- (1) Experts
- (2) Significant others

            (3) Records

        f. Review of literature

            (1) Textbooks

            (2) Journals

    B. Data organization - group data into general categories so it may be examined more readily

        1. Maslow's hierarchy of human needs

        2. Growth and development (Erickson's theory)

        3. Individual school's philosophy

III. Summary and Conclusion

    A. Definition of assessment

    B. Steps of assessment

LESSON PLAN: 2

COURSE TITLE: FUNDAMENTALS OF NURSING CORE CURRICULUM

UNIT III NURSING PROCESS

INTERACTION ITEMS:

1. Why do you think the client is considered the primary source of information?
2. What might be gained from consulting with other members of the health care team?

CLASSROOM, LABORATORY, SHOP OR OTHER ACTIVITIES:

1. List Maslow's hierarchy of human needs in order and give an example of each level.

LESSON PLAN: 2

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT III NURSING PROCESS

EVALUATION ITEMS

1. Define nursing assessment as the first phase of nursing process.

2. List three factors that may influence the client's ability to provide accurate assessment data.

   a.

   b.

   c.

3. Identify three methods of data collection

   a.

   b.

   c.

4. Discuss Maslow's hierarchy of human needs and how this can be used to organize client data.

Mutiple choice: Place the letter of the phrase which correctly answers the question in the space provided.

______ 5. The primary source of data about the client is

a. Previous health records
b. The client
c. Laboratory tests
d. Literature

_____ 6. Which of the following is subjective data?

a. The client states that he/she feels dizzy.
b. The client has a distended abdomen.
c. The client ambulates with a walker.
d. The client has a bruise on his/her left knee.

_____ 7. Which of the following is an objective finding?

a. The client's mother feels that the child is anxious.
b. The child states that he/she worries about school.
c. The child's weight is below normal on a growth chart.
d. The child's teacher reports that the child is quarrelsome.

LESSON PLAN: 2

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT III NURSING PROCESS

ANSWERS TO EVALUATION ITEMS

1. Answers will vary
2. a. Usual response to illness
   b. Ability, inability to communicate
   c. Negative feelings related to illness

3. Any three of the following:

   a. Nursing history
   b. Observation
   c. Physical assessment
   d. Psychosocial assessment
   e. Consultation
   f. Review of the literature

4. Answers will vary
5. b
6. a
7. c

LESSON PLAN: 3

COURSE TITLE: FUNDAMENTALS OF NURSING CORE CURRICULUM

UNIT III NURSING PROCESS

SCOPE OF UNIT:

This unit defines, explains, and illustrates the basic elements of the nursing process and relates the importance of nursing process as the basis of providing nursing care for clients. Comparisons between the process and the clinical unit nursing care plan are drawn.

INFORMATION TOPIC: X OR DEMONSTRATION:

NURSING HISTORY
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Identify the general features of the nursing history.
2. Describe guidelines to use when conducting a nursing history.
3. Identify the appropriate type of question to use to obtain specified data.
4. List the six major areas for data collection in the nursing history.
5. Give examples of questions that would be asked in each area of the nursing history.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Samples of nursing history forms from local hospitals or other health care agencies utilized for student clinical experience

INFORMATIONAL ASSIGNMENT: (Student)

Kozier, B. and G. Erb. Fundamentals of Nursing: Concepts And Procedures. Menlo Park, CA: Addison-Wesley Publishing Co., 1983. pp. 127-130.

Wolff, L., et al. Fundamentals of Nursing. 7th ed. New York: J.B. Lippincott Co. 1983. pp. 203-206.

REFERENCES: (Instructor's Additional Information)

Atkinson, L.D. and M.E. Murray. Understanding The Nursing Process. New York: MacMillan Publishing Company, Inc., 1983.

Kemp, Brenda and Adele Pillitteri. Fundamentals of Nursing. Boston: Little, Brown and Co., 1984.

Murray, Malinda. Fundamentals of Nursing. Englewood Cliffs, NJ: Prentice Hall, Inc., 1980.

Yura, H. and M.B. Walsh. The Nursing Process. New York: Appleton, Century-Crofts, 1981.

INTRODUCTION:

In the last lesson we discussed some of the methods nurses use to collect data about the client. One of the methods mentioned was the nursing history. This lesson will focus on the nursing history as a systematic tool for the collection of data about the client. The nursing history is completed through an interview process. Interviewing is a skill that requires practice in order to be as effective as possible. After we discuss the nursing history and some of the guidelines for you to remember as you do a nursing history, you will be given the opportunity to practice this new skill.

LESSON PLAN: 3

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT III NURSING PROCESS

INFORMATION TOPIC: III-3

OUTLINE: (Key Points)

I. General Features of the Nursing History

  A. Purpose - to collect relevant client data that will form the basis for nursing plans and actions

  B. Differences between Nursing History and Medical History

    1. Medical history seeks specific, factual information about a disease or condition.

    2. Nursing history seeks information about the client's physical, and psychosocial responses to the disease or condition.

  C. Completed as soon as possible after admission to health care agency

II. Guidelines for Nursing Interview

  A. Introduce yourself and sit down.

  B. Explain purpose of interview, which is to learn as much about the client and the situation as possible in order to plan nursing care.

  C. Make the client as comfortable as possible.

  D. Ensure a quiet, private setting without distractions.

  E. Vary the format and the process to accommodate the needs of the client.

  F. Do not collect data that is available elsewhere, except to verify data.

  G. Collect only data that is useful and relevant.

  H. Adhere to your purpose and time limit.

  I. Respect the client's right to privacy and the right to refrain from answering your questions.

  J. Write brief notations, but do not attempt to write every word.

  K. Use appropriate eye contact.

  L. Use terminology the client understands.

M. Call the client by name; do not use words like "honey, gramps."

N. Speak clearly, slowly, and distinctly.

O. LISTEN

III. Types of Questions

A. Closed, direct questions are used to gather specific information.
EXAMPLE: "How long have you had this pain?"

B. Broad, open questions are used to obtain data about the client's feelings, perceptions, attitudes, or beliefs. Allows the client to talk about what is on his/her mind.

EXAMPLE: Would you discuss with me how you feel about your illness?

IV. Areas of the Nursing History

A. Identification data - name, age, sex, marital status, religion, occupations, etc.

B. Current health status - information about the current health problem

INSTRUCTOR NOTE: The following are sample questions that could be asked.

1. What were the symptoms of this health problem?

2. What did you do when you first became aware of these symptoms?

3. What can you do to relieve the symptoms?

4. How do you feel right now?

5. What do you know about this health problem?

6. What do you know about the tests or treatments that have been planned?

7. What do you believe is the likely outcome?

8. Who or what has been your chief source of information about this health problem?

C. Past health history

1. Previous hospitalizations

2. Chronic health problems

3. Allergies

4. Medications

5. Immunizations record

D. Personal and family history

INSTRUCTOR NOTE: The following are sample questions that could be asked.

1. Would you tell me a little about your way of life?

2. How do you stay healthy?

3. What things in your life seem to make it hard to stay healthy?

4. How do you usually react to being ill?

5. How do you like other people to treat you when you are ill?

6. Would you describe a typical day?

E. Review of systems - obtain data relating to any previous problems with each system

1. Integumentary system

2. Visual/auditory system

3. Respiratory system

4. Cardiovascular system

5. Gastrointestinal system

6. Reproductive system

7. Musculoskeletal system

8. Neurological system

9. Endocrine system

10. Immune system

F. Nursing care and assistance needed

INSTRUCTOR NOTE: The following are sample questions that could be asked.

1. What, if anything, don't you understand as well as you would like to?

2. What do you expect of those who will be providing care for you?

V. Summary and Conclusion

   A. General features

   B. Guidelines for nursing interview

   C. Types of questions

   D. Areas of the nursing history

LESSON PLAN: 3

COURSE TITLE: FUNDAMENTALS OF NURSING CORE CURRICULUM

UNIT III NURSING PROCESS

INTERACTION ITEMS:

1. What is the main purpose of doing a nursing history?

2. From your experience, what are some things that might happen to interfere with completing a nursing history effectively?

CLASSROOM, LABORATORY, SHOP OR OTHER ACTIVITIES:

1. Compare the nursing history forms from local hospitals with your class notes, paying attention to the areas usually covered in the nursing history. Do the forms contain data questions for each area? How do the forms differ?

2. Complete a nursing history on a classmate or on a client assigned by your instructor. The classmate should role-play as a client with a typical health problem.

LESSON PLAN: 3

COURSE TITLE: FUNDAMENTALS OF NURSING CORE CURRICULUM

UNIT III NURSING PROCESS

EVALUATION ITEMS

1. You are about to perform a nursing history on a client who has just been admitted to the nursing unit on which you work. Describe five general guidelines for effective interviewing that you would keep in mind as you complete the nursing history.

   a

   b.

   c.

   d.

   e.

2. List the six major content areas for data collection in the nursing history.

   a.

   b.

   c.

   d.

   e.

   f.

3. Discuss the type of information you would be attempting to obtain in two of the areas you listed in the above question. Identify one appropriate question that you would ask to obtain this data.

   a. Type of information:

      Appropriate question:

   b. Type of information:

Appropriate question:

MULTIPLE CHOICE

Directions: Place the letter of the phrase which correctly answers the question in the space provided.

_____ 4. General features of the nursing history include all of the following except:

a. The nursing history is completed as part of assessment activities.
b. The medical history and the nursing history are identical.
c. The nursing history seeks information about the client's physical and psychosocial responses to the disease or condition.
d. The nursing history is usually completed as soon as possible after admission to the health care agency.

_____ 5. Closed, direct questions are typically used to obtain:

a. Information regarding the client's beliefs
b. Information regarding the client's feelings
c. Specific information
d. Closed, direct questions should not be used

LESSON PLAN: 3

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT III NURSING PROCESS

ANSWERS TO EVALUATION ITEMS

1. Answers will vary, but should be based on outline section II, A-0.
2. a. Identification data
   b. Current health status
   c. Past health history
   d. Personal and family history
   e. Review of systems
   f. Nursing care and assistance needed
3. Answers will vary, but should be based on section IV, A-F.
4. b
5. c

LESSON PLAN: 4

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT III NURSING PROCESS

SCOPE OF UNIT:

This unit defines, explains, and illustrates the basic elements of the nursing process and relates the importance of nursing process as the basis of providing nursing care for clients. Comparisons are drawn between the process and the clinical unit nursing care plan are drawn.

INFORMATION TOPIC: X OR DEMONSTRATION:

NURSING PHYSICAL ASSESSMENT
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Relate observations and measurements to be included in the general impression.

2. Describe assessment techniques for:

   a. Skin and nails
   b. Head
   c. Neck
   d. Thorax and lungs
   e. Heart
   f. Breasts and axillae
   g. Abdomen
   h. Genitals and rectum
   i. Muscles and skeleton
   j. Neurological function

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Stethoscope

2. Scale

3. Thermometer

4. Blood pressure cuff

5. Sphygmomanometer
6. Otoscope
7. Flashlight
8. Tongue blade

INFORMATIONAL ASSIGNMENT: (Student)

Kozier, B. and G. Erb. Fundamentals of Nursing: Concepts And Procedures. Menlo Park, CA: Addison-Wesley Publishing Co., 1983. pp. 130-133; 322-357.

Review: Kozier & Erb, pp. 299-321.

Wolff, L., et al. Fundamentals of Nursing. 7th ed. New York: J.B. Lippincott Co. 1983. Chapter 18.

REFERENCES: (Instructor's Additional Information)

INTRODUCTION:

Another method used by nurses to collect data about the client is the physical assessment. This lesson will introduce the components of the physical assessment and you will be given the opportunity to practice these techniques. You are already familar with some of the techniques that are used in physical assessment (measuring BP, pulse, respirations, height and weight). You will also be introduced to some techniques that will be unfamiliar to you. The physical assessment is usually done soon after admission to the health care agency and after the nursing history has been completed. The nursing history gives you some focus for the physical assessment as you will then have some information about past and present health problems of the client.

LESSON PLAN: 4

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT III NURSING PROCESS

INFORMATION TOPIC: III-4

OUTLINE: (Key Points)

I. General Impression

  A. Measure and record height, weight, and vital signs.

  B. Observe appearance, posture, grooming, gait.

II. Assessment of Skin and Nails

  A. Inspect for color and lesions.

  B. Palpate for texture, temperature, and lesions.

III. Assessment of the Head

  A. Face - inspect for symmetry, coordination of facial movements, size and shape of face, and position of facial structures.

  B. Skull

    1. Inspect for symmetry.

    2. Palpate for nodules.

  C. Scalp and hair

    1. Inspect for lesions, hair distribution, and color.

    2. Palpate for lesions.

  D. Eyes

    1. Inspect eyebrows and eyelashes.

    2. Inspect eyelids for discoloration, edema, or lesions.

    3. Inspect sclera and conjunctiva for color.

    4. Observe size, shape and symmetry of pupils.

    5. Inspect cornea and lens for cloudiness or abrasions.

    6. Inspect for symmetry of eye movements.

E. Ears

1. Inspect auricle for size, shape, position and symmetry.

2. Inspect auditory canal for cerumen, discharge, and foreign bodies.

F. Nose

1. Observe size, shape, symmetry.

2. Inspect for discharge.

3. Observe patency of nasal passageway.

G. Mouth and throat

1. Inspect lips for color and moistness.

2. Inspect mucous membranes for color, moistness, and lesions.

3. Inspect teeth for discoloration or caries.

4. Inspect tongue for color, moistness or lesions.

5. Inspect pharynx for color, edema, and presence of tonsils.

IV. Assessment of the Neck

A. Inspect for size, shape, symmetry, range of motion.

B. Palpate for enlarged lymph nodes.

C. Palpate for thyroid.

V. Assessment of the Thorax and Lungs

A. Inspect for posture, shape, and symmetry.

B. Percussion to determine position and size of organs

1. Resonance normally heard over lungs

2. Dullness normally heard over heart or liver

3. Tympany normally heard over stomach or other organs that enclose air or gas

C. Auscultation to identify breath sounds

1. Vesicular

2. Bronchial

3. Bronchovesicular

D. Palpate for symmetry of expansion.

VI. Assessment of the Heart

A. Inspect and palpate for pulsations.

B. Auscultate for apical pulse (S_1 and S_2).

VII. Assessment of the Breasts and Axillae

A. Inspect for size, contour, symmetry, appearance of nipples and areolae.

B. Palpate axillary lymph nodes for enlargement or tenderness and breasts for lesions.

VIII. Assessment of the Abdomen

A. Inspect for rashes, lesions, scars and edema or distention.

B. Inspect for contour and symmetry.

C. Auscultate for bowel sounds in all four quadrants.

D. Palpate for masses or tenderness.

E. Percuss to detect gas, fluid or masses and the position of organs.

IX. Assessment of the Genitals and Rectum

A. Inspect external genitalia for appearance, symmetry, discharge, general state of hygiene, and distribution of pubic hair.

B. Inspect rectum for lesions, hemorrhoids.

C. Palpate for distended testes in the male.

X. Assessment of the Muscles and Skeleton

A. Inspect for symmetry of movement.

B. Observe range of motion of all joints.

C. Inspect for spinal curvature.

D. Observe balance, muscle strength, and coordination.

XI. Assessment of Neurological Function

A. Assess level of consciousness utilizing the Glasgow coma scale.

B. Note speech and mood/emotions.

C. Note appropriateness of behavior.

D. Note basic level of knowledge.

E. Note memory.

  1. Recent
  2. Remote

F. Observe abnormal movements.

XII. Summary and Conclusion

A. General impression

B. Assessment of the skin and nails

C. Assessment of the head

D. Assessment of the neck

E. Assessment of the thorax and lungs

F. Assessment of the heart

G. Assessment of the breasts and axillae

H. Assessment of the abdomen

I. Assessment of the genitals and rectum

J. Assessment of the muscles and skeleton

K. Assessment of neurological functions

LESSON PLAN: 4

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT III NURSING PROCESS

INTERACTION ITEMS:

1. What are some of the factors that may affect a person's height and weight?

2. What is the name of the instrument that is used to inspect the auditory canal?

3. Why is it a good idea to auscultate the abdomen prior to palpating the abdomen?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. The instructor will demonstrate a nursing physical assessment.

2. Practice doing a physical assessment on a mannequin or a classmate.

3. Complete a physical assessment on a client assigned by your instructor and record your findings.

LESSON PLAN: 4

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT III NURSING PROCESS

EVALUATION ITEMS

1. Relate three observations and/or measurements that should be included in the general impression portion of the nursing physical assessment.

   a.

   b.

   c.

2. Describe how you would assess each of the following during a nursing physical assessment:

   a. Skin and nails

   b. Head

   c. Neck

   d. Thorax and lungs

   e. Heart

f. Breasts and axillae

g. Abdomen

h. Genitals and rectum

i. Muscles and skeleton

j. Neurological function

LESSON PLAN: 4

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT III NURSING PROCESS

ANSWERS TO EVALUATION ITEMS

1. Any three of the following:
   a. Height
   b. Weight
   c. Vital signs
   d. Appearance
   e. Posture
   f. Grooming
   g. Gait

2. a. Skin and nails
      1. Inspect for color and lesions
      2. Palpate for texture, temperature, and lesions.

   b. Head
      1. Face - inspect for symmetry, coordination of facial movements, size and shape of face, and position of facial structures.
      2. Skull
         (a) Inspect for symmetry.
         (b) Palpate for nodules.
      3. Scalp and hair
         (a) Inspect for lesions, hair distribution, and color.
         (b) Palpate for lesions.
      4. Eyes
         (a) Inspect eyebrows and eyelashes.
         (b) Inspect eyelids for discoloration, edema, or lesions.
         (c) Inspect sclera and conjunctiva for color.
         (d) Observe size, shape and symmetry of pupils.
         (e) Inspect cornea and lens for cloudiness or abrasions.
         (f) Inspect for symmetry of eye movements.
      5. Ears
         (a) Inspect auricle for size, shape, position and symmetry.
         (b) Inspect auditory canal for cerumen, discharge, and foreign bodies.
      6. Nose
         (a) Observe size, shape, symmetry.
         (b) Inspect for discharge.
         (c) Observe patency of nasal passageway.

      7. Mouth and throat
         (a) Inspect lips for color and moistness.
         (b) Inspect mucous membranes for color, moistness, and lesions.
         (c) Inspect teeth for discoloration or caries.

        - (d) Inspect tongue for color, moistness or lesions.
        - (e) Inspect pharynx for color, edema, and presence of tonsils.

- c. Neck
    1. Inspect for size, shape, symmetry, range of motion.
    2. Palpate for enlarged lymph nodes.
    3. Palpate for thyroid.

- d. Thorax and lungs
    1. Inspect for posture, shape, and symmetry.
    2. Percussion to determine position and size of organs
    3. Auscultation to identify breath sounds
    4. Palpate for symmetry of expansion.

- e. Heart
    1. Inspect and palpate for pulsations.
    2. Auscultate for apical pulse (S_1 and S_2).

- f. Breasts and axillae
    1. Inspect for size, contour, symmetry, appearance of nipples and areolae.
    2. Palpate axillary lymph nodes for enlargement or tenderness and breasts for lesions.

- g. Abdomen
    1. Inspect for rashes, lesions, scars and edema or distention.
    2. Inspect for contour and symmetry.
    3. Auscultate for bowel sounds in all four quadrants.
    4. Palpate for masses or tenderness.
    5. Percuss to detect gas, fluid or masses and the position of organs.

- h. Genitals and rectum
    1. Inspect external genitalia for appearance, symmetry, discharge, general state of hygiene, and distribution of pubic hair.
    2. Inspect rectum for lesions, hemorrhoids.
    3. Palpate for distended testes in the male.

- i. Muscles and skeleton
    1. Inspect for symmetry of movement.
    2. Observe range of motion of all joints.
    3. Inspect for spinal curvature.
    4. Observe balance, muscle strength, and coordination.

- j. Neurological function
    1. Assess level of consciousness utilizing the Glasgow coma scale.
    2. Note speech and mood/emotions.
    3. Note appropriateness of behavior.
    4. Note basic level of knowledge.
    5. Note memory.
        - (a) Recent
        - (b) Remote
    6. Observe abnormal movements.

LESSON PLAN: 5

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT III NURSING PROCESS

SCOPE OF UNIT:

This unit defines, explains, and illustrates the basic elements of the nursing process and relates the importance of nursing process as the basis of providing nursing care for clients. Comparisons between the process and the clinical unit nursing care plan are drawn.

INFORMATION TOPIC: X OR DEMONSTRATION:

NURSING DIAGNOSIS
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Compare and contrast nursing diagnosis and medical diagnosis.
2. Relate the format for a nursing diagnosis.
3. Identify two major types of nursing diagnoses.
4. Distinguish correctly written nursing diagnoses.
5. Determine appropriate nursing diagnoses from a client profile.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. The participating school's list of accepted nursing diagnoses

INFORMATIONAL ASSIGNMENT: (Student)

Kozier, B. and G. Erb. Fundamentals of Nursing: Concepts And Procedures. Menlo Park, CA: Addison-Wesley Publishing Co., 1983. pp. 135-143.

Wolff, L., et al. Fundamentals of Nursing. 7th ed. New York: J.B. Lippincott Co. 1983. pp. 208-210.

REFERENCES: (Instructor's Additional Information)

Atkinson, L.D. and M.E. Murray. Understanding the Nursing Process. New York: Macmillan Publishing Company, 1983.

Gordon, M. Nursing Diagnosis: Process and Application. New York: McGraw-Hill, 1982.

Kim, M.J. and Derry O. Moritz. Classification of Nursing Diagnosis. New York: McGraw Hill Book Co., 1982.

Yura, H. and M.B. Walsh. The Nursing Process. New York: Appleton, Century-Crofts, 1981.

INTRODUCTION:

The second major step in the nursing process is the identification of client health conditions that require nursing intervention. This is called nursing diagnosis. The nursing diagnosis results from the analysis of the data that is collected during the assessment phase of the process. In this lesson we will learn how to analyze the information that was collected in the assessment and how to form a nursing diagnosis.

LESSON PLAN: 5

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT III NURSING PROCESS

INFORMATION TOPIC: III-5

OUTLINE: (Key Points)

I. Definition of Nursing Diagnosis - a statement of a potential or actual altered health status of a client, which is derived from nursing assessment and which requires intervention from the domain of nursing. (Edel, 1982)

II. Differences between Nursing Diagnosis and Medical Diagnosis

  A. Medical diagnosis describes a specific disease process; nursing diagnosis describes an individual's response to a disease process.

  B. Medical diagnosis is oriented to pathology; nursing diagnosis is oriented to the individual.

  C. Medical diagnosis remains constant throughout the duration of the illness; nursing diagnosis changes as the client's responses change.

  D. Medical diagnosis guides medical management, some of which may be carried out by nurses; nursing diagnosis guides independent nursing care.

  E. Medical diagnoses are derived from a well-developed classification system accepted by the medical profession; nursing diagnoses have no universally accepted classification system.

III. Format of Nursing Diagnosis

  A. Statement of the client's response

  B. Contributing factors or probable causes of the response; the two parts are joined by a clause such as "related to" or "associated with"

  C. Examples

    1. Potential for injury related to confusion

    2. Impaired mobility associated with fractured femur

    3. Ineffective coping related to diagnosis of diabetes

IV. Types of Nursing Diagnoses

  A. Actual - client health problems that are present at this time

  B. Potential - health problems that this client is at risk for developing

V. Common Errors in Stating Nursing Diagnoses

   A. Stating in terms of needs rather than problems ("needs to increase fluid intake" should be "fluid volume deficit")

   B. Using the words "due to" to connect the two parts rather than "related to" (may be legally hazardous)

   C. Reversing the two-part statement

   D. Writing two parts of a statement which say the same thing (disoriented to time and place related to confusion)

   E. Using a medical diagnosis as the first part of the nursing diagnosis

VI. Summary and Conclusion

   A. Definition of nursing diagnosis

   B. Differences between medical diagnosis and nursing diagnosis

   C. Format of nursing diagnosis

   D. Types of nursing diagnosis

   E. Common errors in stating nursing diagnosis

LESSON PLAN: 5

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT III NURSING PROCESS

INTERACTION ITEMS:

1. What does the definition of nursing process given in class mean to you?

2. What are the differences between nursing diagnosis and medical diagnosis.

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Using data obtained in previous lessons (nursing history and nursing assessment) analyze the data to determine three nursing diagnoses.

LESSON PLAN: 5

COURSE TITLE: FUNDAMENTALS OF NURSING CORE CURRICULUM

UNIT III NURSING PROCESS

EVALUATION ITEMS

1. Compare and contrast nursing diagnosis and medical diagnosis. (Give at least three differences)

   a.

   b.

   c.

Indicate if the following are correctly written nursing diagnoses; C = correct, I = incorrect.

______ 2. Potential for injury related to impaired mobility

______ 3. Disoriented to time and place related to confusion

______ 4. Force fluids

______ 5. Severe itching related to insect bites

______ 6. Loss of appetite due to chemotherapy

______ 7. Anxiety associated with lack of knowledge about procedure

______ 8. Thrombophlebitis related to prolonged bedrest

______ 9. Intravenous infusion of blood

From the following data, determine two nursing diagnoses

> Mary, a 16 year old, has just given birth to her first child. The nurses have observed her to be nervous and awkward when she handles the baby. She is frequently tearful and says repeatedly "I just don't know what to do." The client's mother spends much time at the hospital, but there is little communication between Mary and her mother. The baby's father has not been to the hospital. Mary is to be discharged in approximately two days.

10. Nursing diagnosis:

11. Nursing diagnosis:

12. Identify the two major types of nursing diagnoses.

a.

b.

______ 13. The format for a nursing diagnosis includes which two components?

a. Problem, symptoms
b. Need, implementation
c. Problem, cause
d. Objective, subjective

LESSON PLAN: 5

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT III NURSING PROCESS

ANSWERS TO EVALUATION ITEMS

1. Any three of the following:
    a. Medical diagnosis describes a specific disease process; nursing diagnosis describes an individual's response to a disease process.
    b. Medical diagnosis is oriented to pathology; nursing diagnosis is oriented to the individual.
    c. Medical diagnosis remains constant throughout the duration of the illness; nursing diagnosis changes as the client's responses change.
    d. Medical diagnosis guides medical management, some of which may be carried out by nurses; nursing diagnosis guides independent nursing care.
    e. Medical diagnoses are derived from a well-developed classification system accepted by the medical profession; nursing diagnoses have no universally accepted classification system.

2. C
3. I
4. I
5. C
6. I
7. C
8. I
9. I

10. Answers will vary, but should reflect an understanding of the purpose and correct format of a nursing diagnosis.

11. Answers will vary, but should reflect an understanding of the purpose and correct format of a nursing diagnosis.

12. a. actual
    b. potential

13. c

LESSON PLAN: 6

COURSE TITLE: FUNDAMENTALS OF NURSING CORE CURRICULUM

UNIT III NURSING PROCESS

SCOPE OF UNIT:

This unit defines, explains, and illustrates the basic elements of the nursing process and relates the importance of nursing process as the basis of providing nursing care for clients. Comparisons between the process and the clinical unit nursing care plan are drawn.

INFORMATION TOPIC: X OR DEMONSTRATION:

PLANNING PHASE

(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Discuss nursing activities involved in the planning phase of nursing process.
2. Utilize Maslow's hierarchy of human needs to set priorities among a group of nursing diagnoses.
3. Identify factors to consider when establishing priorities.
4. Outline the four essential components of the client goal statement.
5. Identify correctly written client goals.
6. Identify correctly written nursing orders.
7. Determine appropriate client goals and nursing orders from simulated data.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

INFORMATIONAL ASSIGNMENT: (Student)

Kozier, B. and G. Erb. Fundamentals of Nursing: Concepts And Procedures. Menlo Park, CA: Addison-Wesley Publishing Co. 1983. pp. 143-151.

Wolff, L., et al. Fundamentals of Nursing. 7th ed. New York: J.B. Lippincott Co. 1983. pp. 210-213.

REFERENCES: (Instructor's Additional Information)

Atkinson, L.D. and M.E. Murray. Understanding the Nursing Process. New York: Macmillan Publishing Company, Inc., 1983.

Kemp, Brenda and Adele Pillitteri. Fundamentals of Nursing. Boston: Little, Brown and Co., 1984.

Murray, Malinda. Fundamentals of Nursing. Englewood Cliffs, NJ: Prentice-Hall, Inc., 1980.

Yura, H. and M.B. Walsh. The Nursing Process. New York: Appleton, Century-Crofts, 1981.

INTRODUCTION:

The third major step of nursing process is planning. The assessment phase consists of data collection and data organization; the second step involves analysis of this data and identification of client problems. After the first two steps are completed the nurse proceeds to determine what actions should be taken to help alleviate the client's problems. Several activities are required for effective planning. We will be discussing these activities in this lesson.

LESSON PLAN: 6

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT III NURSING PROCESS

INFORMATION TOPIC: III-6

OUTLINE: (Key Points)

I. Activities Involved in Planning

    A. Setting priorities

    B. Establishing goals

    C. Writing nursing orders (plan of action)

II. Setting Priorities - determine priorities based on the following:

    A. Maslow's hierarchy of human needs - lower needs must be met before an individual can focus on higher needs

    B. Client preferences - offer client the chance to set own priorities

    C. Nursing resources

III. Establishing Goals--desired outcome of nursing care

    A. Format

        1. Client or any part of client

        2. Verb - the action the client will perform

        3. Criteria of performance - the level at which the client will perform a certain behavior (how long, how far)

        4. Conditions - circumstances under which the behavior will be performed

    B. Categories of goals

        1. Short-term: goal that can be met fairly quickly (hours or days)

        2. Long-term: goal that requires a longer time span to accomplish; several short-term goals may be required to meet a long-term goal

    C. Guidelines to goal writing

        1. Write goals in observable or measurable terms - avoid terms such as "know", "understand", "enjoy."

2. Write goals in terms of client outcomes, not nursing actions. EXAMPLE: "The client will void by 6 p.m.," not "The nurse will offer the client the urinal every hour."

3. Keep the goal concise.

4. Make the goal specific.

5. Each goal should be derived from only one nursing diagnosis.

6. Designate a specific time for achievement of each goal.

IV. Writing a Plan of Action (nursing orders)

A. Categories of nursing orders

1. Orders for nursing therapy of a client problem

2. Orders for collection of additional data to define a client problem better or facilitate its management

3. Orders for dissemination of information about the management of a client problem

B. Guidelines for selection of nursing orders

1. Orders must be safe for client.

2. Orders must be congruent with other therapies.

3. Orders must be based on principles and scientific knowledge.

4. Write one set of orders to accomplish each goal.

5. Choose a set of nursing orders most likely to accomplish the goal.

6. Orders should be realistic for the client, staff, equipment.

7. Consult with client before choosing nursing orders.

8. List nursing orders according to priority.

V. Summary and Conclusion

A. Setting priorities

B. Establishing client goals

C. Writing nursing orders

LESSON PLAN: 6

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT III NURSING PROCESS

INTERACTION ITEMS:

1. Why is it important to consider the client's preference when setting priorities?
2. What is the difference between short-term and long-term goals?
3. What is meant by the statement that nursing orders must be based on scientific principles?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

Look again at the data you collected with the nursing history and the nursing physical assessment of a classmate. Establish goals for the nursing diagnoses you identified with Lesson III-5. Now write a goal for each nursing diagnosis, and nursing orders to accomplish each goal. Review and discuss what you have written in small groups.

LESSON PLAN: 6

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT III NURSING PROCESS

EVALUATION ITEMS

1. Using Maslow's hierarchy of human needs theory, organize the following nursing diagnoses in order of priority, with A as the highest priority, B as second highest, etc.

   ______ Potential for injury related to organic brain syndrome

   ______ Disturbance in self-concept related to loss of job

   ______ Ineffective breathing pattern related to asthma

   ______ Loneliness related to loss of close friends

2. Outline the four essential components of the client goal statement.

   a.

   b.

   c.

   d.

Indicate if the following are correctly written client goal statements; C = correct, I = incorrect.

______ 3. The client's hydration will improve.

______ 4. The client will lose 4 lbs. in two weeks.

______ 5. Offer fluids every 2 hours.

______ 6. The client will express confidence in his/her ability to provide self-care before discharge.

Indicate if the following are correctly written nursing orders; C = correct, I = incorrect.

______ 7. Apply cold compresses to forehead for 15 minutes to help relieve headache.

______ 8. Assist client to walk length of hall t.i.d. to improve circulation.

______ 9. Increase muscle strength in upper extremities.

______ 10. Pain associated with peptic ulcer

11. Priorities are set according to Maslow's hierarchy of human needs, available nursing resources, and ______

    a. Client knowledge
    b. Client age
    c. Nurse preferences
    d. Client preferences

LESSON PLAN: 6

COURSE TITLE: FUNDAMENTALS OF NURSING CORE CURRICULUM

UNIT III NURSING PROCESS

ANSWERS TO EVALUATION ITEMS

1. B
   D
   A
   C

2. a. client
   b. verb
   c. criteria
   d. conditions

3. I
4. C
5. I
6. C
7. C
8. C
9. I
10. I
11. d

LESSON PLAN: 7

COURSE TITLE: FUNDAMENTALS OF NURSING CORE CURRICULUM

UNIT III NURSING PROCESS

SCOPE OF UNIT:

This unit defines, explains, and illustrates the basic elements of the nursing process and relates the importance of nursing process as the basis of providing nursing care for clients. Comparisons between the process and the clinical unit nursing care plan are drawn.

INFORMATION TOPIC: X OR DEMONSTRATION:

IMPLEMENTATION PHASE
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. List the four activities that are involved in the implementation phase of nursing process.
2. Identify and give examples of four areas of nursing intervention.
3. Distinguish the types of nursing actions.
4. Discuss various methods of implementation.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

INFORMATIONAL ASSIGNMENT: (Student)

Kozier, B. and G. Erb. Fundamentals of Nursing: Concepts And Procedures. Menlo Park, CA: Addison-Wesley Publishing Co. 1983. pp. 153-155.

Wolff, L., et al. Fundamentals of Nursing. 7th ed. New York: J.B. Lippincott Co. 1983. pp. 213-216.

REFERENCES: (Instructor's Additional Information)

Atkinson, L.D. and M.E. Murray. Understanding the Nursing Process. New York: Macmillan Publishing Company, 1983.

Kemp, Brenda and Adele Pillitteri. Fundamentals of Nursing. Boston: Little, Brown and Co., 1984.

Mayers, Marlene G. A Systematic Approach to the Nursing Care Plan. Norwolk: Appleton, Century-Crofts, 1983.

Murray, Malinda. Fundamentals of Nursing. Englewood Cliffs, NJ: Prentice-Hall, Inc., 1980.

Yura, H. and M.B. Walsh. The Nursing Process. New York: Appleton, Century-Crofts, 1981.

INTRODUCTION:

The implementation phase of nursing process is the action phase. During this phase the nurse carries out the plan that she/he has devised to help alleviate the client's problems. Not all of the activities in the plan of care are implemented by the nurse, however. It is the nurse's responsibility to supervise and coordinate the care that is provided by the other members of the health care team. Documentation of the care given is also the responsibility of the nurse.

LESSON PLAN: 7

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT III NURSING PROCESS

INFORMATION TOPIC: III-7

OUTLINE: (Key Points)

I. Activities of the Implementation Phase

  A. Implement nursing orders.

  B. Continue to collect data as care is being given.

  C. Continue to develop a helping relationship with the client.

  D. Document care given.

II. Areas of Nursing Implementation

  A. Health maintenance and promotion - wellness; care and prevention of illness

  B. Restoration of health

  C. Rehabilitation to optimal health

  D. Acceptance of death

III. Types of Nursing Actions

  A. Dependent - actions done under the direction of the physician. The action is dependent, but the nurse is still responsible legally and ethically for these actions.

  EXAMPLE: Administration of medications

  B. Interdependent - shared decision

  EXAMPLE: Administration of p.r.n. medications

  C. Independent - actions decided on the basis of nursing knowledge and needed because of nursing skill

  EXAMPLE: Measuring intake and output on a client who has been vomiting

IV. Methods for Implementation

  A. Direct care

1. Teaching
2. Psychomotor skills
3. Comforting
4. Protecting
5. Counseling

B. Supervision of care - care delegated to another member of the health care team. The nurse is still responsible for the care given. Important to delegate to an appropriate person.

C. Coordination of care - the nurse is usually responsible for coordinating the client care activities of many of the members of the health care team.

D. Referral - the nurse often makes referrals to other members of the health care team such as the dietician, the social worker, etc.

V. Documentation of Care Given - the care that is given the client should be documented in the client care record in order to provide legal evidence and to provide for communication among all health care providers.

VI. Summary and Conclusion

A. Activities of the implementation phase

B. Areas of nursing implementation

C. Types of nursing actions

D. Methods for implementation

E. Documentation of care given

LESSON PLAN: 7

COURSE TITLE: FUNDAMENTALS OF NURSING CORE CURRICULUM

UNIT III NURSING PROCESS

INTERACTION ITEMS:

1. What is the difference between a dependent and an independent nursing action?

2. Why do you think it is important to involve clients in their own care?

CLASSROOM, LABORATORY, SHOP OR OTHER ACTIVITIES:

1. In small groups discuss some of your own experiences in which the nursing implementation involved:

   a. Coordination of care

   b. Referral

LESSON PLAN: 7

COURSE TITLE: FUNDAMENTALS OF NURSING CORE CURRICULUM

UNIT III NURSING PROCESS

EVALUATION ITEMS

1. List the four activities that are involved in the implementation phase of nursing process.

   a.

   b.

   c.

   d.

2. List the four areas of nursing intervention.

   a.

   b.

   c.

   d.

3. One of the methods of nursing intervention is providing direct care to clients. Discuss the various nursing activities that are involved in providing direct care.

4. Administering a p.r.n. medication is an example of which type of nursing action?

   a. Dependent
   b. Interdependent
   c. Supervisory
   d. Independent

5. Planning and implementing a nursing order to place an immobilized client on an egg crate mattress to prevent problems with skin breakdown is an example of a ______________ nursing action.

   a. Dependent
   b. Interdependent
   c. Supervisory
   d. Independent

LESSON PLAN: 7

COURSE TITLE: FUNDAMENTALS OF NURSING CORE CURRICULUM

UNIT III NURSING PROCESS

ANSWERS TO EVALUATION ITEMS

1. a. Implementation of nursing orders
   b. Continuing data collection
   c. Continuing development of a helping relationship
   d. Document care given

2. a. Health maintenance and promotion
   b. Restoration of health
   c. Rehabilitation
   d. Acceptance of death

3. Answers will vary
4. b
5. d

LESSON PLAN: 8

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT III NURSING PROCESS

SCOPE OF UNIT:

This unit defines, explains, and illustrates the basic elements of the nursing process and relates the importance of nursing process as the basis of providing nursing care for clients. Comparisons are drawn between the process and the clinical unit nursing care plan.

INFORMATION TOPIC: X OR DEMONSTRATION:

EVALUATION PHASE
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Explain the purpose of evaluation.
2. Describe the two major tasks to be completed in the evaluation phase of nursing process.
3. Identify the proper method of evaluating goal achievement.
4. Identify the nursing responsibilities for changing the nursing care plan upon completion of the evaluation phase.
5. Discuss the advantages of evaluation for the nurse and the client.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

INFORMATIONAL ASSIGNMENT: (Student)

Kozier, B. and G. Erb. Fundamentals of Nursing: Concepts And Procedures. Menlo Park, CA: Addison-Wesley Publishing Co. 1983. pp. 155-159.

Wolff, L., et al. Fundamentals of Nursing. 7th ed. New York: J.B. Lippincott Co. 1983. pp. 217-221.

REFERENCES: (Instructor's Additional Information)

Atkinson, L.D. and M.E. Murray. Understanding the Nursing Process. New York: Macmillan Publishing Company, 1983.

Kemp, Brenda and Adele Pillitteri. Fundamentals of Nursing. Boston: Little, Brown and Co., 1984.

Mayers, Marlene G. A Systematic Approach to the Nursing Care Plan. Norwolk: Appleton, Century-Crofts, 1983.

Murray, Malinda. Fundamentals of Nursing. Englewood Cliffs, NJ: Prentice-Hall, Inc., 1980.

Yura, H. and M.B. Walsh. The Nursing Process. New York: Appleton, Century-Crofts, 1981.

INTRODUCTION:

Evaluation is the final phase of the nursing process. In order to complete this phase, data must be collected to determine if the client goals were met and if the nursing actions were successful. This step, then, brings us back to assessment and illustrates the circular nature of nursing process. Evaluation is a very important part of nursing process. It is just as important to evaluate nursing actions and client responses as it is to plan and implement nursing actions.

LESSON PLAN: 8

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT III NURSING PROCESS

INFORMATION TOPIC: III-8

OUTLINE: (Key Points)

I. Purpose of Evaluation - to decide if the client goal in the nursing care plan has been achieved and what actions to take as a result of this decision.

II. Steps of Evaluation

  A. Evaluation of goal achievement - measured against predetermined standards (client goals)

    1. Client's ability to perform the behavior stated in the goal

      a. Goal met

      b. Goal partially met

      c. Goal not met

    2. Client data to support this decision

  B. Reassessment of care plan - follows the decision on goal achievement; the nurse gathers data continuously throughout all phases of nursing process which leads to decisions on needed changes in the care plan.

  C. Nursing responsibilities based on reassessment

    1. Priorities have changed - one or two of the problems may have become more important and the nursing actions need to be reassessed.

    2. A new problem exists - the nurse must then develop appropriate goals and nursing actions to help with this problem.

    3. Goal met and problem no longer exists - the nursing care plan for this problem is discontinued

    4. Goal met but problem still exists - the nurse decides if the goals or nursing actions were inappropriate and makes necessary changes

    5. Goal not met or partially met - the nurse would make changes in goals or nursing actions if other actions might be more successful

III. Advantages of Evaluation

A. Client - evaluation ensures effective nursing actions since the nurse gets feedback to determine if the care was effective or if the care plan needs to be altered

B. Nurse - evaluation of nursing actions toward goal achievement helps the nurse to learn which nursing actions are the most effective for various problems. The nurse also becomes more proficient at writing appropriate goals

IV. Summary and Conclusion

A. Purpose of evaluation

B. Steps of evaluation

C. Advantages of evaluation

LESSON PLAN: 8

COURSE TITLE: FUNDAMENTALS OF NURSING CORE CURRICULUM

UNIT III NURSING PROCESS

INTERACTION ITEMS:

1. If the evaluation determines that the client goal was met, but the problem has not been resolved what should the nurse do?
2. If the evaluation determines that the client goal was only partially met what should the nurse do?

CLASSROOM, LABORATORY, SHOP OR OTHER ACTIVITIES:

1. What are some of the likely consequences if the evaluation phase of the nursing process is not completed? Give some examples from your own experience.

LESSON PLAN: 8

COURSE TITLE: FUNDAMENTALS OF NURSING CORE CURRICULUM

UNIT III NURSING PROCESS

EVALUATION ITEMS

1. In your own words explain the purpose of the evaluation phase of nursing process.

2. There are two major tasks involved in completing the evaluation phase. Describe each of these.

   a.

   b.

3. Discuss two advantages of using the evaluation phase of nursing process.

   a.

   b.

4. In order to correctly evaluate the effectiveness of the nursing care plan the nurse must compare client behavior with:

   a. Nursing actions
   b. Client goals
   c. Nursing orders
   d. Nursing diagnoses

5. If the evaluation determines that the client goal was met and the client problem no longer exists what is the appropriate nursing action?

   a. Continue the nursing care plan for this goal
   b. Discontinue the nursing care plan for this goal
   c. Discharge the client
   d. Let the client decide

LESSON PLAN: 8

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT III NURSING PROCESS

ANSWERS TO EVALUATION ITEMS

1. Answers will vary, but should include the following:

   ...to decide if the client goal in the nursing care plan has been achieved and what actions to take as a result of this decision

2. A. Evaluation of goal achievement - measured against predetermined standards (client goals)

      1. Client's ability to perform the behavior stated in the goal
         a. Goal met
         b. Goal partially met
         c. Goal not met
      2. Client data to support this decision

   B. Reassessment of care plan - follows the decision on goal achievement; the nurse gathers data continuously throughout all phases of nursing process which leads to decisions on needed changes in the care plan.

3. A. Client - evaluation ensures effective nursing actions since the nurse gets feedback to determine if the care was effective or if the care plan needs to be altered

   B. Nurse - evaluation of nursing actions toward goal achievement helps the nurse to learn which nursing actions are the most effective for various problems. The nurse also becomes more proficient at writing appropriate goals

4. b

5. b

LESSON PLAN: 9

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT III NURSING PROCESS

SCOPE OF UNIT:

This unit defines, explains, and illustrates the basic elements of the nursing process and relates the importance of nursing process as the basis of providing nursing care for clients. Comparisons are drawn between the process and the clinical unit nursing care plan.

INFORMATION TOPIC: X OR DEMONSTRATION:

THE NURSING CARE PLAN
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. List the purposes of the nursing care plan.
2. List the components of the nursing care plan.
3. Discuss the advantages of using the nursing care plan.
4. Write a nursing care plan for an assigned client.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Samples of nursing care plan forms from local hospitals or other health care agencies utilized for student clinical experience.

INFORMATIONAL ASSIGNMENT: (Student)

Kozier, B. and G. Erb. Fundamentals of Nursing: Concepts And Procedures. Menlo Park, CA: Addison-Wesley Publishing Co. 1983. pp. 148-151.

Wolff, L., et al. Fundamentals of Nursing. 7th ed. New York: J.B. Lippincott Co. 1983. p. 213.

REFERENCES: (Instructor's Additional Information)

Atkinson, L.D. and M.E. Murray. Understanding the Nursing Process. New York: Macmillan Publishing Company, 1983.

Kemp, Brenda and Adele Pillitteri. Fundamentals of Nursing. Boston: Little, Brown and Co., 1984.

Mayers, Marlene G. A Systematic Approach to the Nursing Care Plan. Norwolk: Appleton, Century-Crofts, 1983.

Murray, Malinda. Fundamentals of Nursing. Englewood Cliffs, NJ: Prentice-Hall, Inc., 1980.

Yura, H. and M.B. Walsh. The Nursing Process. New York: Appleton, Century-Crofts, 1981.

INTRODUCTION:

The nursing care plan is the written evidence that nursing process is being used to direct client care. It is a way of organizing the nursing process so that the information can be easily communicated to all necessary persons. In order to be as effective as possible, the nursing care plan must be communicated and utilized by all who provide care for the client. The nursing care plan should be written after the planning phase of the nursing process is completed and evaluated after the care plan is implemented. The nursing care plan is a learning tool for the nurse who devises it and also for those implementing the plan. Utilizing a nursing care plan can improve the quality of client care because the plan provides for continuity by all who provide care for the client. Use of the nursing care plan ensures that all aspects of the client (physiological and psychosocial) are systematically assessed, analyzed, and considered as nursing care is planned and implemented. You will find the nursing care plan to be a very effective tool for your learning and for ensuring quality nursing care for clients.

LESSON PLAN: 9

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT III NURSING PROCESS

INFORMATION TOPIC: III-8

OUTLINE: (Key Points)

I. Purposes of the Nursing Care Plan

   A. Plan and implement effective nursing care

   B. Communicate the plan to all those providing care

   C. Provide criteria for evaluation of nursing actions

II. Components of the Nursing Care Plan

   A. Nursing diagnosis - after the assessment phase is completed, the nurse develops a list of client problems including the cause, if known (nursing diagnosis)

   B. Client goals - at least one for each nursing diagnosis; should be stated in measurable terms of client behavior

   C. Nursing orders - selected actions to accomplish the goal

   D. Rationale for nursing orders - the principles upon which the nursing orders are based; not included on the clinical unit nursing care plan, but is helpful for educational purposes

   E. Evaluation - determines if the care plan is effective or needs to be altered

III. Advantages of Nursing Care Plan

   A. Time-saving for nurses - once the assessment and care plan are completed, all nurses can follow without having to devise their own plan of care

   B. Ensures continuity of care for the client

   C. Improves quality of care - all aspects of the client are considered and all alternatives for nursing actions are considered

   D. Encourages client participation in own care - essential for effective nursing process

   E. Professional growth for nurses - the nurse completing the care plan learns as she/he considers all alternatives for nursing actions and those that implement the plan learn of additional actions that are used to alleviate the client problem

F. Provides evidence of quality nursing care - written evidence that nursing care is based on the nursing process

IV. Summary and Conclusion

A. Purposes of the nursing care plan

B. Components of the nursing care plan

C. Advantages of the nursing care plan

LESSON PLAN: 9

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT III NURSING PROCESS

INTERACTION ITEMS:

1. What are the components of the nursing care plan?
2. What advantages do you see from your experience, in using a written nursing care plan?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Using a sample nursing care plan form (provided by your instructor), write a nursing care plan for a client assigned by your instructor. Be sure to include the following:
    a. List all actual and potential client problems in the nursing diagnosis format.
    b. Write realistic, measurable client goals for each nursing diagnosis.
    c. Devise appropriate nursing orders to meet the goals.
    d. Provide rationale for each nursing order.
    e. Evaluate client behavior on the basis of the criteria stated in the goal.

LESSON PLAN: 9

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT III NURSING PROCESS

EVALUATION ITEMS

1. List the three purposes of the nursing care plan.

   a.

   b.

   c.

2. List the components of the nursing care plan.

3. Discuss three advantages of using the nursing care plan.

LESSON PLAN: 9

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT III NURSING PROCESS

ANSWERS TO EVALUATION ITEMS

1. a. Plan and implement effective nursing care
   b. Communicate the plan to all those providing care
   c. Provide criteria for evaluation of nursing actions

2. a. Nursing diagnosis
   b. Client goals
   c. Nursing orders
   d. Rationale for nursing orders
   e. Evaluation

3. Any three of the following:

   a. Time-saving for nurses - once the assessment and care plan are completed, all nurses can follow without having to devise their own plan of care
   b. Ensures continuity of care for the client
   c. Improves quality of care - all aspects of the client are considered and all alternatives for nursing actions are considered
   d. Encourages client participation in own care - essential for effective nursing process
   e. Professional growth for nurses - the nurse completing the care plan learns as she/he considers all alternatives for nursing actions and those that implement the plan learn of additional actions that are used to alleviate the client problem
   f. Provides evidence of quality nursing care - written evidence that nursing care is based on the nursing process

LESSON PLAN: 1

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

SCOPE OF UNIT:

This unit provides an overview of the responsibilities of the RN in medication administration. Drugs are reviewed by characteristics of drug classes. The systems of measurement and methods of conversion between systems are described. Routes of administration and nursing implications are listed. The growing problem of drug abuse is briefly covered.

INFORMATION TOPIC: X OR DEMONSTRATION:

RESPONSIBILITIES OF THE RN IN MEDICATION ADMINISTRATION

(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Identify the laws governing the nurse's administration of drugs.
2. Apply the nursing process steps of assessment, planning, and evaluation to a case study in drug therapy.
3. Differentiate between the role of RN and LPN in drug administration.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

INFORMATIONAL ASSIGNMENT: (Student)

Kozier, B. and G. Erb. Fundamentals of Nursing: Concepts and Procedures. 2nd ed. Menlo Park, CA: Addison-Wesley Publishing Co., 1983. pp. 936-938, 951-952.

Wolff, L., et al. Fundamentals of Nursing. 7th ed. New York: J.B. Lippincott Co. 1983. pp. 38, 721-723.

REFERENCES: (Instructor's Additional Information)

Johns, M. et al. Case Studies in Drug Therapy. New York: Macmillan Publishing Co., Inc., 1979.

Gerald, M. and F. O'Bannon. Nursing Pharmacology and Therapeutics. Englewood Cliffs: Prentice Hall, Inc., 1981.

Spencer, et al. Clinical Pharmacology and Nursing Management. Philadelphia: J.B. Lippincott, 1983.

INTRODUCTION:

Drug administration is one of the nurse's most important responsibilities. Nurses are legally and morally responsible for the safety of the client. They can be held legally responsible for any harm resulting to the client. It thus becomes important for the nurse to understand the laws governing practice, and the use of nursing process in dispensing medication to individual clients. At the conclusion of this class, we will compare this to what was learned in LPN school. Students will be expected to discuss the differences in terms of content and scope of practice.

LESSON PLAN: 1

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

INFORMATION TOPIC: IV-1

OUTLINE: (Key Points)

I. Legal Aspects of Drug Administration

A. Food, Drug, and Cosmetic Act (1938) and its ammendments

1. Requires proof of safety and efficacy before drug can be sold

2. Requires proper labeling and directions on drugs and truthful advertising

3. Made the United States Pharmacopeia and the National Formulary official standards

B. Controlled Substances Act of 1970

1. States it is illegal to possess controlled substances without valid prescription

2. Governs handling of narcotics in health agencies

C. State nurse practice acts

1. Define and limit functions of RNs

2. Hold nurses reponsible for own actions regardless of whether there is written order

II. Use of Nursing Process in Drug Administration

A. Assessment

1. Establish baseline for assessing effects on individual's problem.

a. Patient's statement of problem

b. Other medications currently taking or recently taken

c. Allergies

d. Psychosocial factors

(1) Health care practices

(2) Previous problems with drugs

            (3) Compliance with prescribed therapies

        e. Clinical signs of illness

    2. Consider developmental influences on action of drug.

        a. Children

        b. Elderly

B. Planning

1. Individualize plan for taking medications.

2. Teach drug therapy plan to client and family.

3. Employ measures that support action of drug, i.e., Cimetidine given before meals.

4. Plan for purposeful observation of drug effects.

5. Share observations with other health team members.

C. Evaluation

1. Record beneficial and adverse effects of drug therapy.

2. Reassess person's readiness to maintain drug therapy plan and future instructional needs.

III. Role of RN vs Role of LPN

A. The Missouri Nursing Practice Act clearly states that nursing care given by the licensed practical nurse must be under the direction of a physician or registered professional nurse.

1. LPNs may administer oral, parenteral (excluding IV's), and topical medication.

2. LPNs completing a generic program of education may observe and monitor intravenous fluid treatment, maintain a calculated flow rate and report and document observations and procedures performed.

B. House bill #450 (May, 1983) broadens the scope of LPN practice in IV administration for LPNs completing an approved program of instruction in intravenous therapy.

1. LPNs may calculate rates of infusion, discontinue treatment, add parenteral solutions and piggy-back medication to existing IV lines, change tubing and dressings, initiate peripheral IV therapy and maintain heparin locks.

2. It is stressed that an RN must first assess a client before the LPN would initiate IV fluid treatment.

3. The activities of the LPN are under the direction of the RN in keeping with the RN's professional judgment and standards established in the agency of employ.

V. Summary and Conclusion

A. Legal aspects of drug administration

B. Use of nursing process in drug administration

C. Role of RN vs role of LPN

LESSON PLAN: 1

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

INTERACTION ITEMS:

1. What law protects the consumer from unsafe and/or ineffective medications?
2. Who is responsible if a physician orders the wrong dose on a medication and the RN administers it as written? What law governs your answer?
3. What drug source book is legally mandated as the official standard for information on drugs?
4. What law governs the nursing practice of counting narcotics at the end of each hospital shift?
5. What information must the nurse assess before administering a medication?
6. What are some nursing measures that would support the action of a drug?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

LESSON PLAN: 1

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

EVALUATION ITEMS

1. The law which governs the handling of narcotics in health agencies is: (Circle letter of correct answer)

   a. Food, Drug, and Cosmetic Act

   b. Controlled Substances Act

   c. Nurse Practice Act

   d. MacGruder Narcotic Act

2. Mrs. Jones, 65 years old, has been diagnosed with essential hypertension. She is to begin taking hydrochlorothiazide p.o. 50 mg. b.i.d. (diuretic) and hydralazine p.o. 100 mg. daily (vasodilator). Before beginning therapy, the nurse does a cardiovascular assessment including vital signs and peripheral pulses. The purpose of this exam is to: (Circle letter of correct answer)

   a. Employ measures that support the action of the drug

   b. Increase compliance with drug therapy

   c. Assess the person's readiness to maintain a drug therapy plan

   d. Establish baselines for assessing the effects of the drugs

3. Mrs. Jones confides that she has had many episodes of hives and irritability after taking medication for an irritable colon. In using the nursing process, the nurse should: (Circle letter of correct answer)

   a. Explain that these are not the same kinds of medications and she probably won't have a reaction to these medicines.

   b. Obtain a listing of the medications she has taken and further elicit Mrs. Jones' feelings about taking these new medications.

   c. Understand that the elderly worry about changes in their routine more than any other age group and reassure Mrs. Jones that everything will be okay.

   d. Teach Mrs. Jones about the action of the drugs and possible side effects.

4. In the space provided, place a "T" if the statement is true, or an "F" if it is false.

_____ LPNs may initiate IV fluid treatment after they have assessed the client.

_____ LPNs may administer oral medication.

_____ LPNs may be taught on the job by other staff members how to add parenteral solutions and piggy-back medication to existing IV lines without having to complete a formal educational program.

LESSON PLAN: 1

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

ANSWERS TO EVALUATION ITEMS

1. b
2. d
3. b
4. F
   T
   F

LESSON PLAN: 2

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

SCOPE OF UNIT:

This unit provides an overview of the responsibilities of the RN in medication administration. Drugs are reviewed by characteristics of drug classes. The systems of measurement and methods of conversion between systems are described. Routes of administration and nursing implications are listed. The growing problem of drug abuse is briefly covered.

INFORMATION TOPIC: X OR DEMONSTRATION:

DRUG CLASSIFICATIONS
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Recognize information that should be included on a drug card.

2. Explain how drugs act on the body and identify the physiologic factors and variables affecting action.

3. Define the following terms:

   a. Toxicity
   b. Allergy
   c. Tolerance
   d. Cumulative effect
   e. Idiosyncratic effect
   f. Drug interaction
   g. Iatrogenic disease

4. Match the actions and uses and common side effects for classes of drugs.

5. State the extent of the information that can be obtained from the various sources of drug information.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. TM 1: Ideal Antimicrobial Agent

2. TM 2: Autonomic Effects on Selected Organs of the Body

3. TM 3: Functions of the Central Nervous System

4. TM 4: Cardiovascular System
5. TM 5: Gastrointestinal System
6. TM 6: Respiratory System
7. TM 7: Major Endocrine Glands
8. TM 8: Stage of Action of Common Antineoplastic Drugs
9. HO 1: Example of Drug Card
10. HO 2: Classification of Drugs Outline
11. HO 3: Major Physiological Effects of Glucocorticoids

INFORMATIONAL ASSIGNMENT: (Student)

Kozier, B. and G. Erb. Fundamentals of Nursing: Concepts and Procedures. 2nd ed. Menlo Park, CA: Addison-Wesley Publishing Co., 1983. pp. 938-942.

REFERENCES: (Instructor's Additional Information)

Malseed, R. Pharmacology: Drug Therapy and Nursing Considerations. Philadelphia: J.B. Lippincott Company, 1982.

Spencer, et al. Clinical Pharmacology and Nursing Management. Philadelphia: J.B. Lippincott, 1983.

INTRODUCTION:

In the last unit, it was implied that one of the nurse's responsibilities includes knowledge of the medication being administered. There are some 25,000 drugs and drug products available in North America today. It is impossible for a nurse to know all these drugs. What the nurse must know is: a) classifications of drugs so that individual drugs can be related to their classes, and b) sources of information that describe drugs. In this lesson, you will be given a brief overview of the classifications as well as information related to effective administration of drugs

LESSON PLAN: 2

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

INFORMATION TOPIC: IV-2

OUTLINE: (Key Points)

I. Drug Cards (HO 1)

  A. These cards are completed on each medication the student administers in the clinical setting. Information which must be on the cards is:

    1. Drug classification
    2. Brand name and generic name of drug
    3. Dosage
    4. Route of administration
    5. Actions and uses
    6. Side effects
    7. Contraindications
    8. Nursing implications of drug

  B. These cards are filed under the appropriate drug classification so the student can see common characteristics and nursing implications.

  C. It is understood that knowledge of groups of drugs grows with clinical experience.

II. Actions of Medications

  A. Definition of drug action

    1. Chemical interaction between the drug and body
    2. Generally a stimulation or inhibition of the function of cells

  B. Physiologic factors affecting action

    1. Absorption of drugs
    2. Circulation of body fluids
    3. Metabolism

4. Excretion

C. Variables influencing drug action

1. Age and weight
2. Sex
3. Genetic factors
4. Psychologic factors
5. Illness and disease
6. Time of administration
7. Environment

D. Effects of drugs

1. Therapeutic and side effects
2. Unexpected effects
   a. Toxicity - deleterious effects of drug on tissue
   b. Allergy - immunologic reaction in sensitized person
   c. Tolerance - low physiologic activity in response to drug
   d. Cumulative effect - one dose is not metabolized before the next dose is added
   e. Idiosyncratic effect - unpredictable, unexpected effects in an individual client
   f. Drug interaction - two drugs administered close together potentiate or inhibit each other
   g. Iatrogenic disease - disease caused unintentionally by medical therapy

III. Classifications of Drugs

INSTRUCTOR NOTE: Distribute HO 2 for use with the following lecture information.

A. Drugs used for inflammations and infections

1. Antiseptics and disinfectants
   a. Used to control growth and infective capability of microorganisms in the environment
      (1) Antiseptics used topically on body

(2) Disinfectants used on inanimate objects

b. Nurse provides thorough cleansing before use

c. Examples in this group are alcohol (antiseptic) and Lysol (disinfectant)

d. Alcohol wipes should not be applied to sterile surface (IV top). Their action is through the mechanical cleansing of friction, not through the disinfectant action of the few seconds of contact.

2. Systemic antimicrobials (TM 1)

a. Ideal antimicrobial destroys microscopic pathogens without harming host cells.

b. Because all living organisms share same basic characteristics, the host is not completely safe; ideal does not exist.

c. Have spectrum of activity (number and type of organisms vulnerable to its action)

d. Limited power if pathogen develops resistance to drug through mutation of host cells

e. Nurse minimizes chance of resistance to drugs through discouraging unnecessary use and encouraging hygienic measures to reduce risk of infection.

f. Examples of drugs in this group

(1) Sulfonamides - commonly used for urinary tract infections

(2) Penicillins - used against strep infections, gonorrhea and many common infections; dangerous allergic reactions possible

(3) Aminoglycosides like streptomycin, gentamycin, tobramycin - used against gram negative organisms and in combination with other antibiotics; ototoxic, nephrotoxic

(4) Cephalosporins - used for septicemia and infections of skin, bones, urine, and respiratory tract; some cross-sensitivity with penicillins

(5) Tetracyclines - used for acne, mycoplasma pneumonia, and when pathogen is resistant to other antimicrobials; calcium products inactivate it

(6) Erythromycins - used for strep infection when penicillin contraindicated

        - (7) Chloramphenical - can cause aplastic anemia, used only when other treatments ineffective
        - (8) Urinary tract antiseptics like Pyridium and Furadantin

3. Anti-infectives for nonbacterial disease
    - a. Antifungals like nystatin (topical) and amphotericin B (systemic)
    - b. Antimalarials like quinine
    - c. Antiprotozoan like Flagyl

4. Antipyretics
    - a. Drugs capable of reducing the abnormally high temperatures of febrile illness
    - b. Nurse responsible for consistent temperature monitoring and awareness that inflammation and pain accompanying disease may be suppressed.
    - c. Examples in this group are aspirin, Tylenol, steroids, quinine.

5. Anti-inflammatory agents
    - a. Inflammation is a protective mechanism to contain infection. When natural process causes deleterious effects, anti-inflammatory agents used.
    - b. Since these drugs cause gastrointestinal disturbance, the nurse should identify the client at risk, give these drugs with milk or food, and inform physician of GI complaints.
    - c. Some of these drugs cause blood changes; hematological profiles should be done on clients on long-term therapy.
    - d. Examples of drugs in this group:
        - (1) Aspirin
        - (2) Butazolidin
        - (3) Indocin
        - (4) Motrin
        - (5) Gold
        - (6) Drugs for gout

6. Agents for wound debridement
    - a. Wounds cannot heal readily in presence of tissue debris or

purulent exudate so chemical agents can supplement mechanical debridement.

b. Nurse should be aware that wound must be kept clean and that agents which debride can cause bleeding by dissolving clots.

c. Examples in this group are:

(1) Hydrogen peroxide

(2) Proteolytic enzymes like Elase

B. Drugs affecting the nervous system

1. Drugs affecting autonomic nervous system (TM 2)

a. Nursing indications with adrenergic drugs are provision for rest, food when drug effects are minimal, reassurance about apprehension that results from drug, and monitoring of cardiovascular problems.

b. Nursing implications with cholinergic drugs are to watch for early signs of urinary and intestinal obstruction and bronchial asthma.

c. Examples of drugs in this group are:

(1) Adrenergic compounds like epinephrine

(2) Adrenergic blockers like Inderal

(3) Cholinergic drugs like acetylcholine

(4) Anticholinergic drugs like atropine

2. Drugs affecting the central nervous system (TM 3)

a. Nurses need to be aware of abuse potential of this group

b. Examples of this group are:

(1) Stimulants (xanthines)

(2) Depressants (analgesics like morphine)

(3) Anticonvulsants (barbituates)

(4) Psychoactive drugs (covered in mental health clinical)

C. Drugs affecting the heart and vessels (TM 4)

1. Nurses need to have understanding of cardiac emergencies and interventions to make.

2. Examples in this group are:

    a. Cardiotonics (digitalis)

    b. Antiarrhythmics (quinidine)

    c. Hypolipemics (Atromid)

    d. Vasodilators (nitroglycerine)

    e. Vasoconstrictors or vasopressors (some of adrenergic drugs in this category like epinephrine)

    f. Anticoagulants (heparin)

D. Drugs affecting the gastrointestinal tract (TM 5)

1. Nurse needs to be aware that these drugs suppress symptoms of underlying disease; make certain there is definitive diagnosis and treatment.

2. Nurse should teach effects of diet, hydration, activity, and stress on GI system.

3. Examples of drugs in this group are:

    a. Digestants (bile salts)

    b. Drugs which reduce hyperacidity (anticholinergics and antacids)

    c. Antiflatulents (Mylicon)

    d. Antimetics (phenothiazines)

    e. Laxatives (MOM, cascara)

    f. Antidiarrheals (Lomotil)

E. Drugs affecting the respiratory system (TM 6)

1. Nurse should check for obstruction or constriction to maintain airway adequacy.

2. Respiratory support care takes up large part of nursing functions and are in addition to pharmacologic measures.

3. Examples of drugs in this group are:

    a. Bronchodilators (Alupent)

    b. Antitussive drugs (codeine, dextromethorphan)

    c. Expectorants (Robitussin)

F. Hormones and hormone antagonists (TM 7)

1. Steroids

a. Used for replacement therapy, for treatment of inflammatory, allergic, or malignant conditions

b. Have serious side effects which must be weighed against benefits (HO 3)

c. The drug cannot be discontinued abruptly.

d. Example is prednisone.

2. Androgens

3. Estrogens

4. Insulin

5. Thyroid hormones

G. Skeletal muscle relaxants

1. Skeletal muscle is voluntary and characterized by ability to contract and relax, thereby moving bones.

2. Injury to muscle system causes painful spasm.

3. No completely satisfactory way of relieving spasm; major side effects relate to sedation.

4. Examples in this group are

(a.) Soma

(b.) Robaxin

(c.) Valium

H. Diuretics

1. These drugs induce the body to lose water and sodium by increasing production of urine.

2. They work by reducing reabsorption of sodium and other solutes from renal tubule; certain electrolytes will always be lost with water

3. Must distinguish between diuretics that cause loss of potassium (like Lasix and hydrochlorothiazide) and diuretics which spare potassium like Aldactone

I. Antineoplastic drugs (TM 8)

1. Different drugs in protocol work in different phases.

2. The different classes of drugs in this group work to kill cancer cells in various phases of its growth. Also includes certain antibiotics and hormones.

3. Given in combination to increase therapeutic effectiveness

4. Since these also affect fast-growing, healthy cells, common side effects relate to alopecia, nausea and vomiting, bone marrow suppression

J. Anti-allergy drugs

1. The body releases histamine when the body reacts to a foreign substance.

2. Histamine causes symptoms that range from hives, asthma, and GI symptoms to complete cardiovascular or respiratory collapse.

3. Common drugs are Chlor-Trimeton and Benadryl.

K. Immunizing agents

L. Nutritional supplements

IV. Sources of Drug Information

A. The Pharmacopeia of the United States of America (U.S.P.)

1. Contains lists of official drugs of the U.S.

2. Includes information on preparation and dispensing of drugs

3. Contains little medical and no nursing information

B. Textbooks - books written for students of nursing, medicine, and pharmacology; only nursing texts give specific nursing implications of administration of specific drugs

C. Journals - give up-to-date information about new drugs and new drug problems

D. Pharmaceutical firms - this includes the P.D.R. (Physician's Desk Reference) and package inserts; information is controlled in part but can still be slanted to promote use of their products

E. Pharmacist - when other sources do not yield needed information, the pharmacist can be consulted

V. Summary and Conclusion

A. Drug cards

B. Actions of medications

C. Classifications of Drugs

D. Sources of Drug Information

LESSON PLAN: 2

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

INTERACTION ITEMS:

1. How might the time of administration affect the action of the drug?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Differentiate between side effects and unexpected effects.

LESSON PLAN: 2

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

EVALUATION ITEMS

1. Place a check (✓) by each component that should be included on a drug card.

_____ a. Side effects

_____ b. Dosage

_____ c. Brand name

_____ d. Cost per unit

_____ e. Route of administration

_____ f. Color of medication

For each of the following, place a "T" in front of the statement if it is true, or an "F" if it is false.

_____ 2. A person with impaired circulation of body fluids will not have rapid therapeutic effects following oral medication administration.

_____ 3. Sex of a client can affect drug action.

_____ 4. A drug action is the idiosyncratic relationship between a drug and the host body cells.

5. Write brief definitions of the following terms:

a. Drug interaction

b. Cumulative effect

c. Iatrogenic disease

Match the following types of drugs with an action associated with that group.

_____ 6. Anti-infectives

_____ 7. Cardiovascular drugs

_____ 8. Diuretics

_____ 9. Antineoplastic drugs

_____ 10. Hormones

a. Counteracts fight or flight reaction

b. Aids digestion

c. Kills protozoa

d. Dilates vessels

e. Glucocorticoid replacement

f. Interferes with cell cycle

g. Suppresses cough

h. Promotes fluid loss through kidneys

11. A nurse wants to review drug information that will be needed to teach a client about his drug. Place a check (✓) before the best sources of this kind of information.

_____ The Pharmacopeia of the United States of America

_____ A medical textbook on pharmacology

_____ A nursing journal that lists drug information

_____ The Physician's Desk Reference (PDR)

_____ A nursing textbook on clinical pharmacology

LESSON PLAN: 2

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

ANSWERS TO EVALUATION ITEMS:

1. ✓ a. ___ d.
   ✓ b. ✓ e.
   ✓ c. ___ f.

2. T
3. T
4. F

5. a. Two drugs administered close together potentiate or inhibit each other
   b. One dose is not metabolized before the next dose is added
   c. Disease caused unintentionally by medical therapy

6. c
7. d
8. h
9. f
10. e

11. ___ The Pharmacopeia of the United States of America
    ___ A medical textbook on pharmacology
    ✓ A nursing journal that lists drug information
    ___ The Physician's Desk Reference (PDR)
    ✓ A nursing textbook on clinical pharmacology

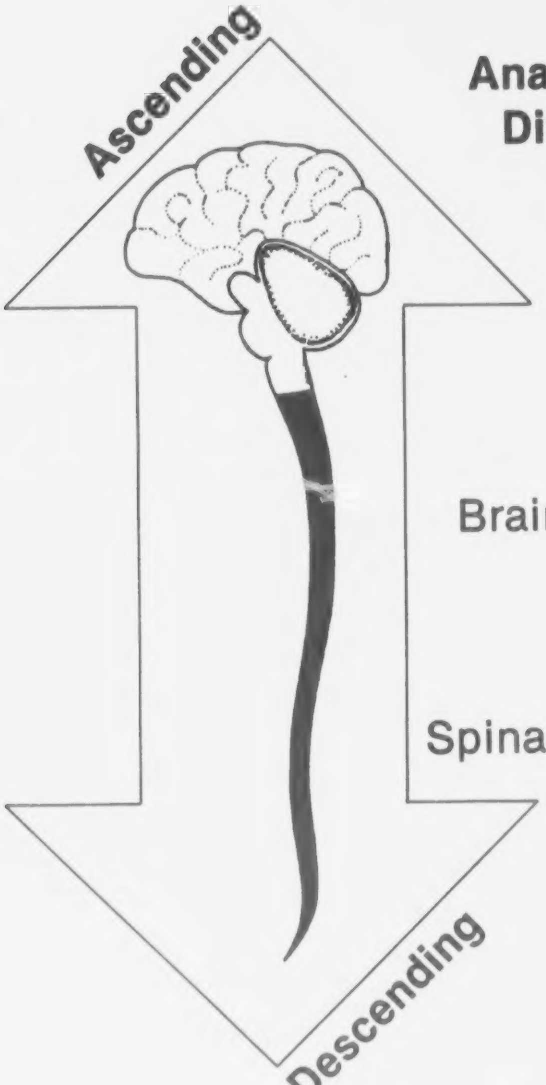
Ideal Antimicrobial Agent

1. Kills a wide spectrum of pathogens
2. Has little effect on normal flora of the body
3. Produces no harm to body tissue
4. Avoids development of resistance by pathogens
5. Avoids development of allergic reactions
6. Maintains therapeutic effectiveness despite presence of enzymes and exudate
7. Provides a therapeutic concentration of the drug in all body fluids and tissues

Autonomic Effects on Selected Organs of the Body

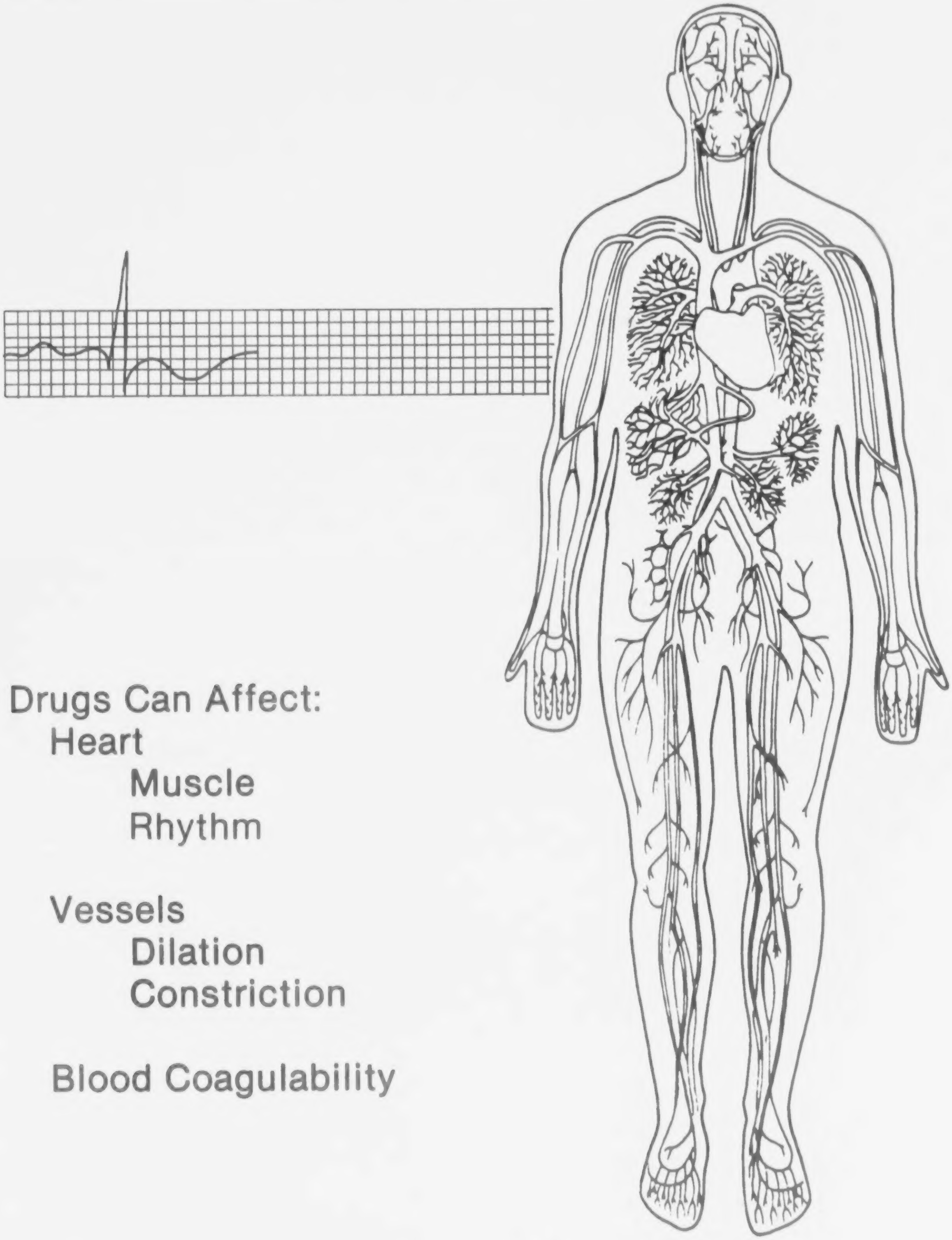
Organ	Parasympathetic (cholinergic)	Sympathetic (adrenergic)
1. Eye	Pupil constricted	Pupil dilated
2. Heart and vessels	Decreases rate Dilates vessels	Increases rate Increases blood pressure
3. Lungs	Constricts bronchi	Dilates bronchi
4. Gut	Increases peristalsis and tone	Decreases peristalsis and tone
5. Kidney and Bladder	Excited	Inhibited

Functions of the Central Nervous System



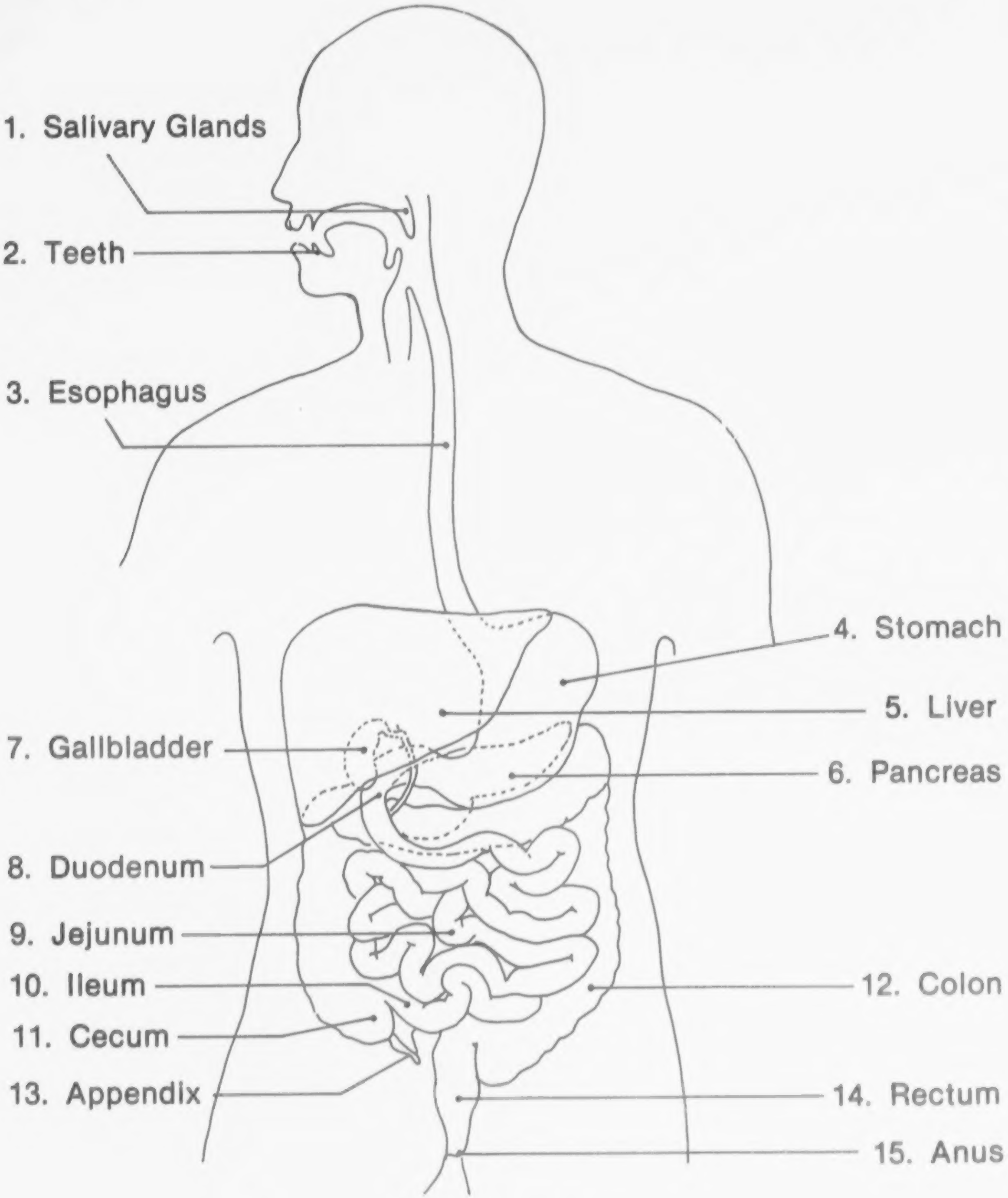
Anatomic Division	Function
Brain	• Conscious Thought • Sensory Perceptions • Motor Controls • Emotion
Brainstem	• Vegetative Function Control • Impulse Conduction
Spinal Cord	• Impulse Conduction • Cord Reflexes

Cardiovascular System

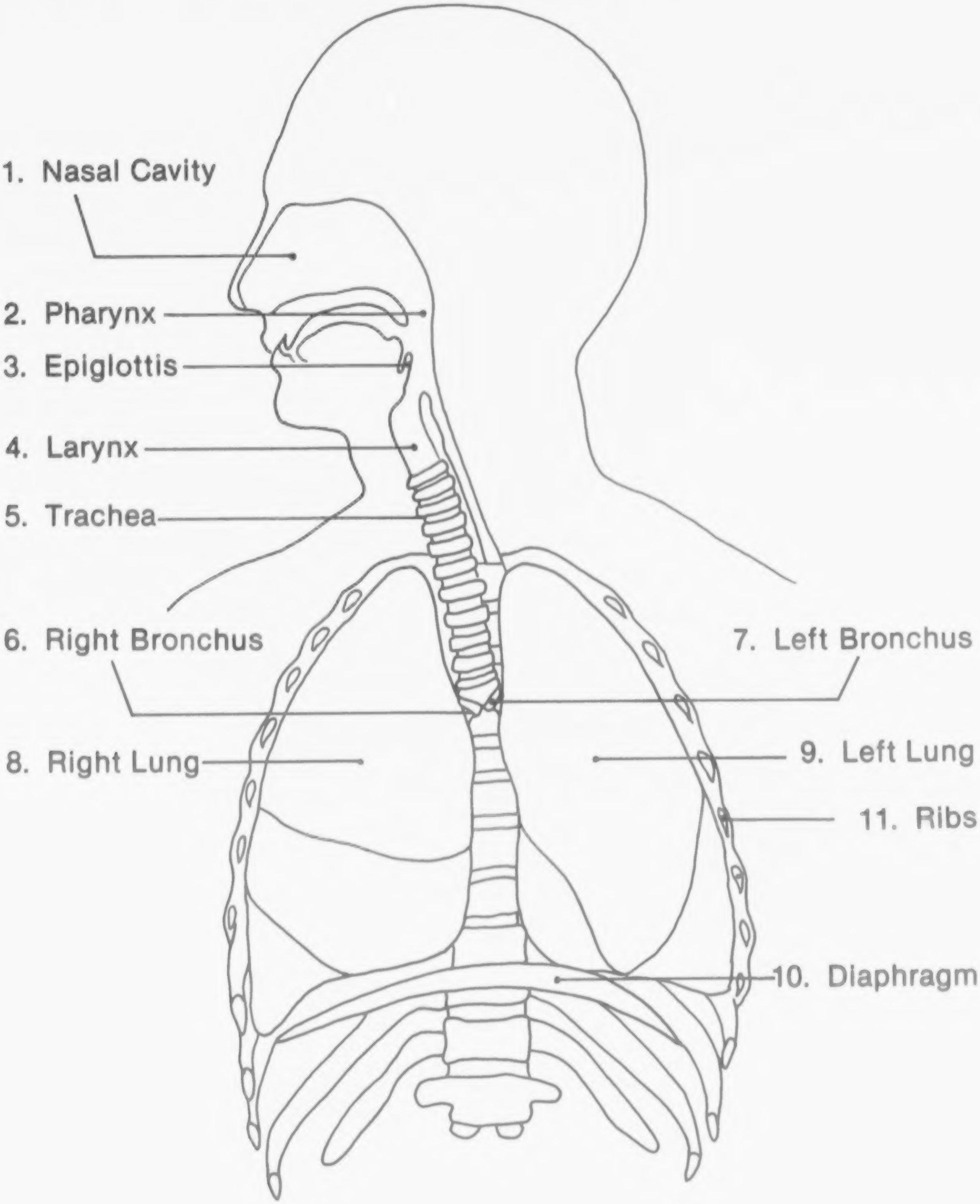


Drugs Can Affect:
- Heart
  - Muscle
  - Rhythm
- Vessels
  - Dilation
  - Constriction
- Blood Coagulability

Gastrointestinal System

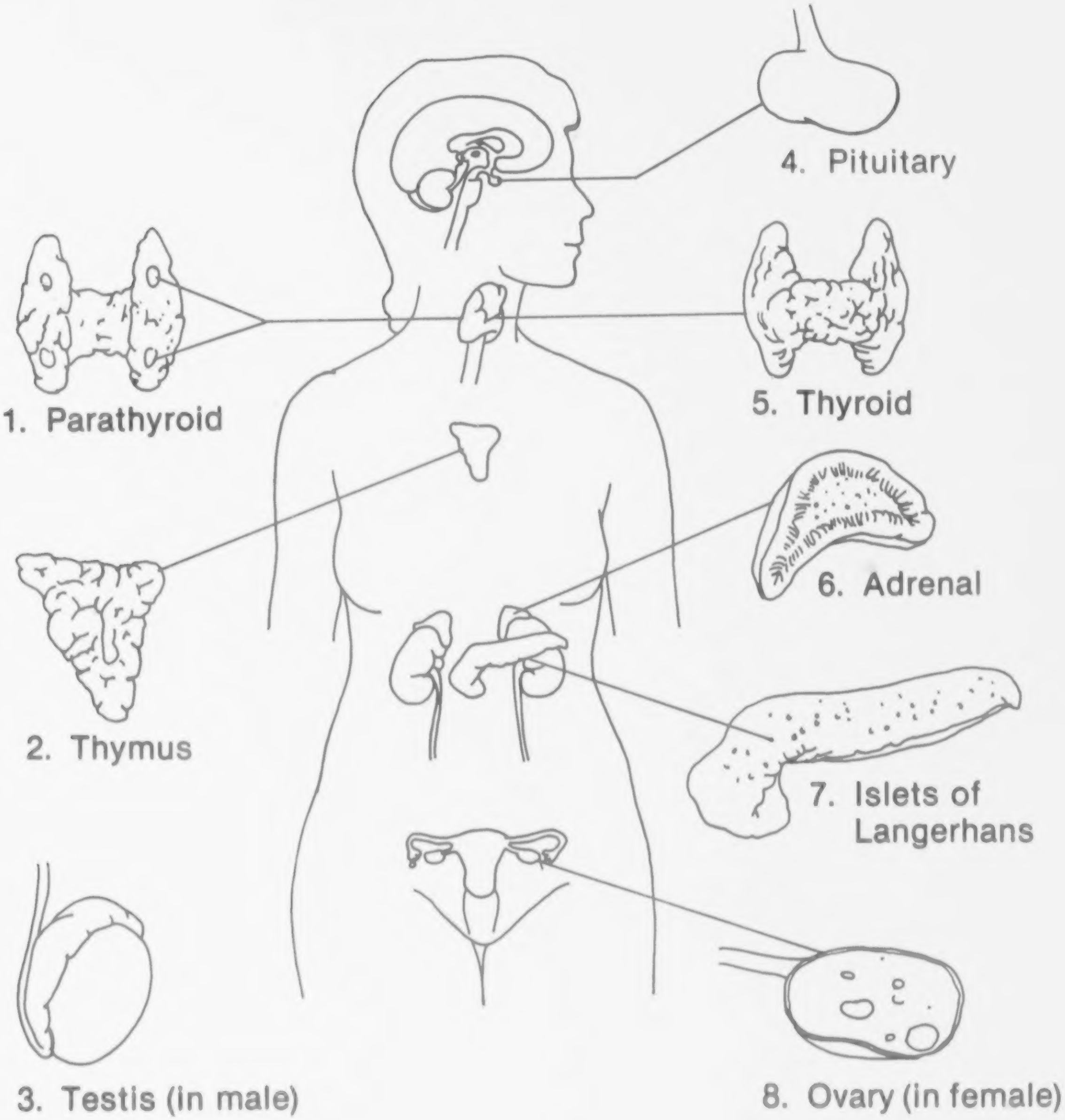

1. Salivary Glands
2. Teeth
3. Esophagus
4. Stomach
5. Liver
6. Pancreas
7. Gallbladder
8. Duodenum
9. Jejunum
10. Ileum
11. Cecum
12. Colon
13. Appendix
14. Rectum
15. Anus

Respiratory System


1. Nasal Cavity
2. Pharynx
3. Epiglottis
4. Larynx
5. Trachea
6. Right Bronchus
7. Left Bronchus
8. Right Lung
9. Left Lung
11. Ribs
10. Diaphragm

TM 7

Major Endocrine Glands


4. Pituitary
1. Parathyroid
5. Thyroid
2. Thymus
6. Adrenal
7. Islets of Langerhans
3. Testis (in male)
8. Ovary (in female)

Stages of Action of Common Antineoplastic Drugs

Stage of Cell Cycle	Drug
I DNA replication	Anti-metabolites: 5 - Fluorouracil 6 - Mercaptopurine Cytosine Arabinoside
II Division of two sets of DNA between two nuclei	Plant Alkaloids: Vincristine Vinblastine
III Splitting of cell to two new cells	
IV Resting period	Alkylating Agents: Chlorambucil Nitrogen Mustard Antibiotics: Adriamycin Bleomycin (form complexes with DNA inhibiting DNA activity)

Example of a Drug Card

Diuretic

Name - (Brand & Generic): **Diuril** (Hydrochlorothiazide)

Normal Dose: 25-100 mg. / day in several doses

R.O.A. (Route of Administration): p.o.

Patient Dose: 25 mg. p.o. BID (in pencil)

Action: Interferes with tubular reabsorption of sodium in the kidney. Used in the management of edema and hypertension (Examples: CHF, hepatic ascites, nephrotic syndrome)

Side Effects: Excessive loss of fluid and electrolytes (Na^+, $C1^-$, K^+), low salt syndrome (mouth dryness and thirst, fatigue, weakness, drowsiness, muscle cramps, pain, nausea, vomiting, diarrhea)

Contraindications: Patients with cirrhosis of the liver, renal shutdown, hypersensitivity to thiazides and sulfonamide (antibacterial) drugs

Nursing Implications: Observe for side effects. Observe for effectiveness (i.e., weight loss, decrease abdominal girth, lowering of B.P.): Teach patient to recognize symptoms of low salt syndrome. Instruct patient to consume foods high in potassium each day (provide list) or request physician to order a supplement. Inform patient to expect an increase in urine output and frequency a few hours after taking the drug. Schedule administration so that drug is not given before bedtime. Alert staff to be ready to assist patient to bathroom as often as necessary.

Classification of Drugs Outline

I. Drugs Used for Inflammations and Infections

  A. Antiseptics and disinfectants

    1. Use

    2. Nursing Responsibility

    3. Examples

  B. Systemic Antimicrobials

    1. Effectiveness limited by

    2. Nursing responsibility

    3. Examples

      a.

      b.

      c.

      d.

      e.

      f.

      g.

      h.

C. Anti-infectives for nonbacterial disease

   1. Antifungal

   2. Antimalarial

   3. Antiprotozoan

D. Antipyretics

   1. Use

   2. Nursing responsibility

   3. Examples

E. Anti-inflammatory agents

   1. Use

   2. Nursing responsibility

   3. Examples

F. Agents for wound debridement

   1. Use

   2. Nursing responsibility

   3. Examples

II. Drugs Affecting the Nervous System

A. Drugs affecting autonomic nervous system

   1. Uses

   2. Nursing responsibility

3. Examples

B. Drugs affecting the central nervous system

1. Uses

2. Nursing responsibility

3. Examples

a.

b.

c.

d.

III. Drugs Affecting the Heart and Vessels

A. Uses

B. Nursing Responsibility

C. Examples

1.

2.

3.

4.

5.

6.

IV. Drugs Affecting the Gastrointestinal Tract

A. Uses

B. Nursing Responsibility

C. Examples

1.

2.

3.

4.

5.

6.

V. Drugs Affecting the Respiratory System

A. Uses

B. Nursing Responsibility

C. Examples

1.

2.

3.

VI. Hormones and Hormone Antagonists

A. Use

B. Nursing Responsibility

C. Examples

1.

2.

3.

4.

VII. Skeletal Muscle Relaxants

A. Use

B. Nursing Responsibility

C. Examples

VIII. Diurectics

A. Use

B. Nursing Responsibility

C. Examples

IX. Antineoplastic Drugs

A. Use

B. Nursing Responsibility

C. Examples

X. Anti-allergy Drugs

A. Use

B. Nursing Responsibility

C. Examples

XI. Immunizing Agents

XII. Nutritional Supplements

HO 3

Major Physiological Effects of Glucocorticoids

Mechanism of Action	Prolonged, Excessive Action
1. Favors formation of glucose for energy including conversion of proteins and fats to glucose	a. Increased blood sugar (diabetes mellitus in susceptible individuals) b. Muscle wasting c. Abnormal fat distribution (buffalo hump, moon faces)
2. Promotes sodium and water retention	a. Edema b. Hypertension
3. Favors potassium excretion	a. Weakness b. Fatigability
4. Suppresses inflammation	Serious infections with few symptoms
5. GI tract (mechanism obscure)	Peptic ulcers
6. Stimulates the brain and reduces impulse transmission	a. Insomnia b. Euphoria c. Blunts the senses
7. Inhibits adrenocorticotropin secretion by pituitary	Adrenal atrophy
8. Increases red blood cell production and coagulability	Polycythemia and increased incidence of thrombi
9. Inhibits cell division	Growth retardation and poor healing

LESSON PLAN: 3

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

SCOPE OF UNIT:

This unit provides an overview of the responsibilities of the RN in medication administration. Drugs are reviewed by characteristics of drug classes. The systems of measurement and methods of conversion between systems are described. Routes of administration and nursing implications are listed. The growing problem of drug abuse is briefly covered.

INFORMATION TOPIC: X OR DEMONSTRATION:

GENERAL PRINCIPLES OF MEDICATION ADMINISTRATION

(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Match the type of medication order with the nursing action implied by the order.
2. Identify the essential parts of a drug order.
3. State the areas of medication knowledge the nurse must have, i.e., actions and side effects of drugs, contraindications, emergency care for adverse effects, nursing implications.
4. Name the general safeguards the nurse uses in actual administration of any drug.
5. Differentiate between information that is legally essential to record and information that is not required.
6. List the advantages and disadvantages of oral administration.
7. Name the types of oral medications.
8. Identify general guidelines of oral administration of drugs.
9. Define parenteral administration.
10. Name an advantage and disadvantage to the parenteral route.
11. List general guidelines for the parenteral route of medication administration.

12. Define topical medication administration and give general nursing considerations.

13. List general guidelines for instillation of medications in eye, ear, nose, and vagina.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

INFORMATIONAL ASSIGNMENT: (Student)

Kozier, B. and G. Erb. Fundamentals of Nursing: Concepts and Procedures. 2nd ed. Menlo Park, CA: Addison-Wesley Publishing Co., 1983. pp. 944-947, 952-956.

Wolff, L., et al. Fundamentals of Nursing. 7th ed. New York: J.B. Lippincott Co. 1983. pp. 675-684.

REFERENCES: (Instructor's Additional Information)

Gerald, M. and F. O'Bannon. Nursing Pharmacology and Therapeutics. Englewood Cliffs: Prentice-Hall, 1983.

Malseed, R. Pharmacology: Drug Therapy and Nursing Considerations. Philadelphia: J.B. Lippincott, 1982.

Spencer, et al. Clinical Pharmacology and Nursing Management. Philadelphia: J.B. Lippincott, 1983.

INTRODUCTION:

In this unit we prepare for actual administration of the drug. We will review interpretation of medication orders, general nursing actions that provide safeguards to the patient, and documentation of the administered medication. We will discuss advantages and disadvantages of oral parenteral and topical administration and general guidelines for administration by each route.

LESSON PLAN: 3

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

INFORMATION TOPIC: IV-3

OUTLINE: (Key Points)

I. Clear Interpretation of Medication Orders

  A. Definition of medication order, including types

    1. Stat order - a medication given immediately and only once

    2. Single order - a medication given once at a specified time

    3. Standing order - a medication given indefinitely until an order is written to cancel it

    4. p.r.n. order - a medication given when the nurse judges that the patient requires it

  B. Essential parts of drug order

    1. Full name of patient

    2. Date

    3. Name of drug

    4. Dosage

    5. Method of administration

    6. Signature

  C. Communicating a medication order

  D. Problems with a medication order

    1. Illegible directions

    2. Drug or dosage unsuitable for patient

    3. Patient inability to take or tolerate drug

    4. Order in violation of agency policy

  E. Medications from home

II. Understanding of Medication Involved

- A. Indications of medication for individual patient including possible contraindications, as in renal failure
- B. Knowledge of actions, therapeutic ranges, and side effects of medications
  - 1. Involves constant updating of knowledge
  - 2. Awareness of sources of information
- C. Knowledge of how to provide emergency care for adverse effects should they arise

III. Safeguards to Maximize Safety and Efficiency of All Drugs During Actual Administration

- A. Careful identification of patient
- B. Administration of drug
  - 1. Medical asepsis
  - 2. Five rights of patient
    - a. Right drug
    - b. Right dose
    - c. Right patient
    - d. Right time
    - e. Right route
  - 3. Read label on container three times.
  - 4. Nurse who prepares medication administers and charts.
  - 5. Medications to withhold
    - a. Unmarked containers
    - b. Cloudy solutions
    - c. Sediments
  - 6. No returning of medication to container
  - 7. Patient's rights in drug administration
    - a. Knowledge of drug
    - b. Refusal of drug

8. Policy for medications left at bedside

C. Problems with administration, i. e., vomiting, dysphagia, etc.

IV. Recording

A. Essential information

1. Date
2. Time
3. Medication name
4. Dose given
5. Method of administration
6. Route of administration
7. Name and title of person administering

B. Additional evaluatory information

1. Pulse or blood pressure with cardiovascular drug
2. Pain relief with analgesic

V. Oral Administration

A. Advantages

1. Safer
2. Least expensive method
3. Pleasanter - natural route of ingestion
4. More convenient

B. Disadvantages

1. May have unpredictable absorption
2. May injure teeth or GI mucosa
3. May be inactivated by gastric acid
4. Contraindicated in patients who are vomiting, unconscious, unable to swallow, or who have gastric or intestinal suction

C. Types of oral medication

1. Tablets and capsules swallowed whole

2. Chewable tablets
3. Sublingual tablets
4. Lozenges

D. General guidelines for oral administration

1. Patient should be in sitting position.
2. Meds should be followed by sufficient fluid to propel into stomach.
3. Enteric coated and time-release capsules cannot be crushed.
4. Dysphagic patients should have elixers or meds crushed in their unit dose packages and placed in juice, applesauce, or ice cream. The tongue may be numbed by sucking ice before giving.
5. Crushed meds can be administered through feeding tubes preceded and followed by one ounce of water.
6. It is advisable to take one tablet at a time to prevent aspiration.

VI. Parenteral Administration

A. Definition - parenteral means "outside of the intestinal tract and includes:

1. Subcutaneous
2. Intradermal
3. Intramuscular
4. Intravenous

B. Advantage - quicker absorption; therapeutic response is achieved faster

C. Disadvantages

1. Same quick absorption makes drug irretrievable so toxic effects occur more rapidly.
2. There is also a break in the skin and the potential for nerve damage.

D. General guidelines

1. Solution given must be sterile and of the proper osmotic pressure to prevent injury to tissues.
2. All parts of the system that come in contact with the medication must be kept sterile.

3. Compatible drugs can be mixed in the same syringe to reduce the number of injections. Tables of compatibility should be used.

4. The site chosen should have adequate vascularity and be free of infection to aid absorption.

VII. Topical Applications

- A. Involves absorption through the epidermis
- B. Used for variety of reasons
  - 1. Itching
  - 2. Lubrication
  - 3. Cause vasoconstriction or vasodilation
  - 4. Increase or decrease skin secretions
  - 5. Provide protective coating
  - 6. Apply an antibiotic or antiseptic
- C. Types of preparations include lotions, emollients, liniments, ointments, pastes, and powders

VIII. Instillations

- A. Eye medications
  - 1. Administered within the lower lid
  - 2. Techniques are aimed toward prevention of bacterial contamination of the solution and spread of infection between eyes
- B. Ear medications
  - 1. Should be near room temperature to prevent vertigo
  - 2. Is a clean procedure; sterile asepsis if the eardrum is perforated
- C. Nose drops - should only be aqueous solutions since are easily aspirated
- D. Vaginal medication
  - 1. Comes in form of suppository and cream
  - 2. Insertion is done with special applicator and gloved hand.
  - 3. Generally given at bedtime since the patient will be maintaining a recumbent position for a prolonged period.

IX. Summary and Conclusion

- A. Clear interpretation of medication orders
- B. Understanding of medication involved
- C. Safeguards to maximize safety and efficiency of all drugs during actual administration
- D. Recording
- E. Oral administration
- F. Parenteral administration
- G. Topical applications
- H. Instillations

LESSON PLAN: 3

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

INTERACTION ITEMS:

1. How does the nurse ensure that the right patient receives the right medication?
2. Why are oral medications the most frequently used?
3. What administration information should you have about a tablet before giving it?
4. What types of medications cannot be crushed?
5. How can a nurse help a dysphagic patient take his/her oral medications?
6. When can parenteral drugs be mixed in the same syringe?
7. What nursing measures increase absorption of topical medications?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

LESSON PLAN: 3

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

EVALUATION ITEMS:

Match the actions in the second column with the appropriate type of order in the first column.

_____ 1. Single order a. A nurse administers an analgesic to a patient when he/she complains of pain.

_____ 2. Stat order b. A nurse administers a preoperative medication

_____ 3. Standing order c. A nurse administers the 9 a. m. dose of Robaxin which is ordered qid.

_____ 4. p.r.n. order d. A nurse administers a dose of Lasix immediately after the physician indicates this is needed for a patient in respiratory distress.

5. What essential part of a drug order is missing in the following statement?

Mary Jones 2-5-85
Monistat vaginal cream at bedtime x 7 days.
Dr. J. Smith

6. A nurse is to administer Vitamin K IV push. Place a check (✓) before the knowledge she must have before administration.

_____ a. Nursing measures appropriate for an adverse reaction to Vitamin K.

_____ b. Contraindications to the individual patient receiving Vitamin K.

_____ c. Teaching material to share with the patient's wife.

7. In the space provided, place a "T" if the statement concerning nursing safeguards in drug administration is true, or an "F" if it is false.

______ a. The patient has a right to refuse a drug.

______ b. No medications can ever be left at the bedside.

______ c. A medication should immediately be repeated if a client vomits right after administration.

8. The following items are information the nurse might list when recording drug information. Place a check mark (✓) before the information that is legally essential.

______ a. Time of administration

______ b. Effects of analgesic on pain relief

______ c. Route of administration

______ d. Name and title of person administering the medication

______ e. Blood pressure and pulse of a person receiving Inderal (anti-hypertensive)

9. Place a "T" for true or an "F" for false before the following items:

______ a. Medications taken orally have a more predictable absorption rate.

______ b. Oral medications are absorbed quicker than parenteral meds.

______ c. Oral medications are contraindicated in patients who have intestinal suction.

______ d. There is more than one way to ingest oral meds.

______ e. An advantage of parenteral medication is the increased speed through the GI tract.

______ f. Parenteral solutions that do not have the proper osmolality can injure tissue

______ g. Rubbing topical medications into the skin increases absorption.

______ h. Asepsis is not necessary with eye or ear instillations since the patient puts his/her finger in these areas.

LESSON PLAN: 3

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

ANSWERS TO EVALUATION ITEMS:

1. b
2. d
3. c
4. a

5. Dosage amount

6. a. ✓
   b. ✓
   c.

7. a. T
   b. F
   c. F

8. a. ✓
   b.
   c. ✓
   d. ✓
   e.

9. a. F
   b. F
   c. T
   d. T
   e. F
   f. T
   g. T
   h. F

LESSON PLAN: 4

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

SCOPE OF UNIT:

This unit provides an overview of the responsibilities of the RN in medication administration. Drugs are reviewed by characteristics of drug classes. The systems of measurement and methods of conversion between systems are described. Routes of administration and nursing implications are listed. The growing problem of drug abuse is briefly covered.

INFORMATION TOPIC: OR DEMONSTRATION: X

PREPARATION AND ADMINISTRATION OF ORAL MEDICATIONS
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Prepare and administer individual oral medications according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Kardex
2. Medicine cards or MAR (medication administration record)
3. Medicine cups
4. Medication
5. Sink and soap

INFORMATIONAL ASSIGNMENT: (Student)

Kozier, B. and G. Erb. Fundamentals of Nursing: Concepts and Procedures. 2nd ed. Menlo Park, CA: Addison-Wesley Publishing Co., 1983. pp. 956-959.

Wolff, L., et al. Fundamentals of Nursing. 7th ed. New York: J.B. Lippincott Co. 1983. pp. 683-686.

REFERENCES: (Instructor's Additional Information)

INTRODUCTION:

Oral administration is the route of choice for the majority of medications. It is safer and more pleasant for the patient. Because this is the most frequent route, the nurse must know the correct procedure to prevent sloppy habits.

LESSON PLAN: 4

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

DEMONSTRATION TOPIC: IV-4

STEPS OF PROCEDURE

1. Check medication card with Kardex. If there is discrepancy, check the physician's order.

   NOTE: Medication errors are the most common nursing errors and this measure decreases chance of error.

2. Check medication against medication card.

3. Wash hands.

4. Pour desired number of capsules into bottle cap and then medication cup.
   OR
   Pour the liquid medicine into a measuring medication cup with eyes level with cup.

   NOTE: Clean technique discourages contact of drug with nurse's hand.

5. Read the label again and replace the cap of the container.

6. Match the medications with the proper patient by keeping med card and cup together or marking the cup. Always keep medication in sight once it is poured.

   NOTE: This decreases the chance of administering the medication to the wrong patient.

7. Identify yourself and explain your purpose as you approach the patient.

8. Identify patient by checking identification band and calling his/her name. Check allergy band to assure this medication is safe for this patient

   NOTE: Calling the name alone is insufficient since many people become confused in the hospital.

9. Assist the patient into an upright position.

   NOTE: This makes swallowing easier.

10. Offer water or permitted fluid.

NOTE: Liquids facilitate swallowing. Make certain the liquid doesn't inhibit absorption of the drug. It is inadvisable to give liquids with antacids if they are meant to coat the GI tract.

11. Place the pill on the back of the tongue if patient requires assistance.

12. Remain with patient until medication is swallowed.

NOTE: The nurse cannot be certain the med is swallowed unless he/she remains. It may be necessary to check the patient's mouth to see if it is swallowed.

13. Offer additional fluids if indicated by the drug, especially if the drug irritates the stomach.

NOTE: Liquids promote quicker absorption of the medication.

14. Return patient to position of comfort.

15. Record the amount of fluid intake consumed during drug administration.

NOTE: Nurses frequently fail to record fluids taken with drugs. This decreases the accuracy of the intake/output record.

16. Immediately record all medications given. Also record if the med was refused or omitted.

NOTE: When a medication is recorded, there is less chance of another nurse repeating the medication.

SUMMARY AND CONCLUSION

1. Discuss interaction items.
2. Review steps of procedure.

LESSON PLAN: 4

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

INTERACTION ITEMS:

1. Why are capsules poured into the cap before being poured into the cup?
2. Why is calling out the patient's name an insufficient way to identify the patient?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Have students follow steps of oral administration set up in the clinical lab.
    a. Orders and medication cards (or MARs) are present which students must check against each other.
    b. Administer an elixer and a tablet medication
    c. Check wristband on patient (mannequin). Have an allergy band on the patient which lists a medication the student is to give.

LESSON PLAN: 4

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

EVALUATION ITEMS

NAME OF STUDENT: ______________________________

PREPARATION AND ADMINISTRATION OF ORAL MEDICATIONS

DID THE STUDENT	Yes	No
1. Check the medication card with the Kardex.		
2. Check medication against medication card.		
3. Wash hands.		
4. Pour medication into cap and then the medication cup.		
5. Read the label again and replace the cap of the container.		
6. Keep the medication in sight once it is poured.		
7. Identify self and explain purpose to the patient.		
8. Identify patient by checking identification band.		
9. Assist patient into an upright position.		
10. Offer water.		
11. Place the pill on the back of the tongue if patient requires assistance.		
12. Remain with patient until medication is swallowed.		

DID THE STUDENT	Yes	No
13. Offer additional fluids if indicated by the drug.		
14. Return patient to the position of comfort.		
15. Record the amount of fluid intake consumed.		
16. Record the medications given.		

The student has satisfactorily completed the procedure "Preparation and Administration of Oral Medications" according to the steps outlined.

Instructor's Signature
(Verifying Satisfactory Completion)

(Date)

LESSON PLAN: 5

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

SCOPE OF UNIT:

This unit provides an overview of the responsibilities of the RN in medication administration. Drugs are reviewed by characteristics of drug classes. The systems of measurement and methods of conversion between systems are described. Routes of administration and nursing implications are listed. The growing problem of drug abuse is briefly covered.

INFORMATION TOPIC: OR DEMONSTRATION: X

PREPARATION AND ADMINISTRATION OF INTRAMUSCULAR INJECTIONS
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Prepare and administer intramuscular injections according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Kardex
2. Medicine cards or MAR (medication administration record)
3. Vial or ampule of solution
4. Alcohol pledgets
5. Syringe with 20 to 23 gauge needle

INFORMATIONAL ASSIGNMENT: (Student)

Kozier, B. and G. Erb. Fundamentals of Nursing: Concepts and Procedures. 2nd ed. Menlo Park, CA: Addison-Wesley Publishing Co., 1983. pp. 968-973.

Wolff, L., et al. Fundamentals of Nursing. 7th ed. New York: J.B. Lippincott Co. 1983. pp. 685, 692-700.

REFERENCES: (Instructor's Additional Information)

INTRODUCTION:

Intramuscular injections are intrusive and can cause fear in some patients. Once the medication has been given by this route, it cannot be retrieved nor the effects delayed. Therefore, it is important that the nurse follow the recommended procedure to ensure patient safety and decrease pain and anxiety.

LESSON PLAN: 5

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

DEMONSTRATION TOPIC: IV-5

STEPS OF PROCEDURE

1. Check medication card with Kardex.

2. Check medication against medication card.

3. Wash hands.

4. Gather drug, syringe with 20 to 23 gauge needle and 1" to 1 1/2" length, and alcohol pledget.

   NOTE: Choice of needle size and length can vary with viscosity of drug and thinness of patient.

5. Draw up the prescribed dosage using aseptic technique.

6. Identify self and purpose for approaching patient.

7. Identify the patient by checking the wristband.

8. Select a site and position patient to relax muscles in this site.

   NOTE: Usual areas chosen are gluteus medius, ventrogluteal, vastus lateralis, and deltoid. Sites are varied according to integrity of tissue, immobility of patient, and amount and viscosity of drug. The drug will be absorbed more quickly from a relaxed muscle.

9. Place a small air bubble in syringe.

   NOTE: The air bubble replaces the drug left in the needle shaft and keeps the drug in the intramuscular tissue.

10. Cleanse skin in circular motion with alcohol pledget.

11. Hold skin taut and quickly insert needle at 90° angle.

    NOTE: Many intramuscular injections fall short of the muscle.

12. Withdraw plunger to watch for blood return. Withdraw needle and replace it and choose another site if blood returns.

    NOTE: Drugs meant for intramuscular area can cause serious reaction if injected into vessel.

13. Inject drug slowly and remove needle quickly.

NOTE: Minimizes trauma to the tissue

14. Apply pressure or massage site of injection.

NOTE: Increases absorption

15. Discard syringe and needle in designated area.

NOTE: The nurse assumes responsibility for preventing reuse of drug equipment.

16. Immediately record all medications given.

SUMMARY AND CONCLUSION

1. Discuss interaction items.
2. Review steps of procedure.

LESSON PLAN: 5

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

INTERACTION ITEMS:

1. Why would a nurse choose a 20 gauge needle over a 22 gauge needle?
2. What sites are used for intramuscular injections?
3. What is the purpose of placing a small air bubble in the syringe?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Have a station set up in the clinical laboratory at which the following activities are performed:
    a. Have tubex syringe and prefilled cartridge for student to practice loading and unloading.
    b. Have students draw from a vial that requires calculation of dosage, i.e., give Keflin 250 mg from a vial Keflin 500 mg per cc.
    c. Have students point out sites for intramuscular injection.
    d. Have student successfully inject into a chosen site according to the steps of procedure.

LESSON PLAN: 5

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

EVALUATION ITEMS

NAME OF STUDENT: ____________________

PREPARATION AND ADMINISTRATION OF AN INTRAMUSCULAR INJECTION

DID THE STUDENT	Yes	No
1. Check the medication card with the Kardex.		
2. Check medication against medication card.		
3. Wash hands		
4. Gather syringe and needle of appropriate size.		
5. Draw up the prescribed dosage using aseptic technique.		
6. Identify self and purpose to patient.		
7. Identify patient by checking wristband.		
8. Select a site and position patient to relax muscle.		
9. Place small air bubble in syringe.		
10. Cleanse skin in circular motion with alcohol pledget.		
11. Hold skin taut and quickly insert needle at 90° angle.		
12. Withdraw plunger to watch for blood return.		

DID THE STUDENT		Yes	No
13.	Inject drug slowly and remove needle quickly.		
14.	Apply pressure and/or massage site of injection.		
15.	Discard syringe and needle in designated area.		
16.	Immediately record all medications given.		

The student has satisfactorily completed the procedure "Preparation and Administration of Intramuscular Injections" according to the steps outlined.

Instructor's Signature
(Verifying Satisfactory Completion)

(Date)

DID THE STUDENT	Yes	No
13. Inject drug slowly and remove needle quickly.		
14. Apply pressure and/or massage site of injection.		
15. Discard syringe and needle in designated area.		
16. Immediately record all medications given.		

The student has satisfactorily completed the procedure "Preparation and Administration of Intramuscular Injections" according to the steps outlined.

Instructor's Signature
(Verifying Satisfactory Completion)

(Date)

LESSON PLAN: 6

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

SCOPE OF UNIT:

This unit provides an overview of the responsibilities of the RN in medication administration. Drugs are reviewed by characteristics of drug classes. The systems of measurement and methods of conversion between systems are described. Routes of administration and nursing implications are listed. The growing problem of drug abuse is briefly covered.

INFORMATION TOPIC: OR DEMONSTRATION: X

PREPARATION AND ADMINISTRATION OF SUBCUTANEOUS INJECTIONS
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Prepare and administer subcutaneous injections according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Kardex
2. Medicine cards or MAR (medication administration record)
3. Vial or ampule of solution
4. Alcohol pledgets
5. Syringe with 25 gauge needle

INFORMATIONAL ASSIGNMENT: (Student)

Kozier, B. and G. Erb. Fundamentals of Nursing: Concepts and Procedures. 2nd ed. Menlo Park, CA: Addison-Wesley Publishing Co., 1983. pp. 963-968.

Wolff, L., et al. Fundamentals of Nursing. 7th ed. New York: J.B. Lippincott Co. 1983. pp. 692-694.

REFERENCES: (Instructor's Additional Information)

INTRODUCTION:

Subcutaneous injections are chosen over intramuscular because drugs administered by this route are absorbed relatively slowly and provide a more sustained effect. This route is appropriate for small doses when nonirritating solutions are used. Because subcutaneous injections carry the same risk of infection, tissue injury, and patient anxiety that other administration routes do, the nurse must be aware of the correct procedure.

LESSON PLAN: 6

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

DEMONSTRATION TOPIC: IV-6

STEPS OF PROCEDURE

1. Check medication card with Kardex.

2. Check medication against medication card.

3. Wash hands.

4. Gather drug, syringe with 5/8" 25 gauge needle and alcohol pledget using sterile technique.

   NOTE: Protect needle from prolonged air exposure or contact with work surface by replacing needle cover immediately.

5. Draw up prescribed dosage using aseptic technique.

6. Identify self and purpose for approaching patient.

7. Identify patient by checking wristband.

8. Select injection site, varying it and cleanse with alcohol pledget using circular motion center outward.

   NOTE: Sites usually selected are outer aspect of arm, thigh, abdomen.

9. Hold skin taut or cushion it and inject the needle quickly at a 90° angle.

   NOTE: Traction on skin and angle of insertion (45° to 90°) can be varied if subcutaneous tissue is decreased in very thin or dehydrated persons.

10. Withdraw plunger slightly to see if blood returns. If blood returns; withdraw, change needle, and choose another site.

    NOTE: A serious reaction can occur if a drug intended for subcutaneous injection enters a vessel.

11. Inject solution slowly and withdraw needle quickly.

    NOTE: These measures minimize patient pain by avoiding rapid expansion of and pulling on tissue.

12. Apply pressure or massage area gently.

    NOTE: This increases absorption of drug.

13. Discard syringe with needle in designated area.

NOTE: The nurse assumes responsibility for preventing reuse of drug equipment.

14. Immediately record all medications given.

SUMMARY AND CONCLUSION

1. Discuss interaction items.
2. Review steps of procedure.

LESSON PLAN: 6

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

INTERACTION ITEMS:

1. What sites are usually chosen for subcutaneous injection?
2. Why is the 25 gauge needle chosen for injection?
3. Why would a nurse give a subcutaneous injection at a 45° angle?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Have a station set up in the clinical laboratory at which the following activities are performed:
    a. Orders and medication cards (or MARs) are present which students must check against each other.
    b. Have NPH and regular insulin which student must draw into one syringe.
    c. Have student point out sites for subcutaneous injection on mannequin and inject subcutaneously.

LESSON PLAN: 6

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

EVALUATION ITEMS

NAME OF STUDENT: ______________________________

PREPARATION AND ADMINISTRATION OF A SUBCUTANEOUS INJECTION

DID THE STUDENT		Yes	No
1.	Check the medication card with the Kardex.		
2.	Check medication against medication card.		
3.	Wash hands.		
4.	Gather syringe and needle of appropriate size.		
5.	Draw up the prescribed dosage using aseptic technique.		
6.	Identify self and purpose for approaching patient.		
7.	Identify patient by checking wristband.		
8.	Select a correct site.		
9.	Cleanse with alcohol pledget using a circular motion center outward.		
10.	Hold skin taut or cushion it, depending on size of patient.		
11.	Inject the needle quickly at a 90° angle.		
12.	Withdraw plunger to watch for blood return.		

DID THE STUDENT	Yes	No
12. Inject drug slowly and withdraw needle quickly.		
13. Apply pressure and/or massage site of injection.		
14. Discard syringe and needle in designated area.		
15. Immediately record all medications given.		

The student has satisfactorily completed the procedure "Preparation and Administration of Subcutaneous Injections" according to the steps outlined.

Instructor's Signature
(Verifying Satisfactory Completion)

(Date)

LESSON PLAN: 7

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

SCOPE OF UNIT:

This unit provides an overview of the responsibilities of the RN in medication administration. Drugs are reviewed by characteristics of drug classes. The systems of measurement and methods of conversion between systems are described. Routes of administration and nursing implications are listed. The growing problem of drug abuse is briefly covered.

INFORMATION TOPIC: OR DEMONSTRATION: X

PREPARATION AND ADMINISTRATION OF INTRADERMAL INJECTIONS
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Prepare, administer, report and record intradermal injections according to the steps of procedure.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Medicine cards or MAR (medication administration record)
2. Tuberculin syringe
3. Alcohol swabs
4. Normal saline for injection
5. Needle disposal box
6. Marker

INFORMATIONAL ASSIGNMENT: (Student)

Kozier, B. and G. Erb. Fundamentals of Nursing: Concepts and Procedures. 2nd ed. Menlo Park, CA: Addison-Wesley Publishing Co., 1983. pp. 689-692.

Wolff, L., et al. Fundamentals of Nursing. 7th ed. New York: J.B. Lippincott Co. 1983. p. 974.

REFERENCES: (Instructor's Additional Information)

INTRODUCTION:

Intradermal injections are used for allergy testing. Producing a small bleb under the skin that indicates a successful injection takes practice but is fun to achieve.

LESSON PLAN: 7

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

DEMONSTRATION TOPIC: IV-7

STEPS OF PROCEDURE

1. Check medication card against physician's order.

2. Wash hands.

3. Prepare the tuberculin syringe with a small amount of liquid (0.1 - 0.2 ml).

   NOTE: This is used for allergy and tuberculin tests and the response will be contained with only a small amount of antigen.

4. Identify self and purpose for approaching patient.

5. Identify patient by checking wristband.

6. Locate the site of choice.

   NOTE: Common sites are the inner lower arm, the upper chest, and back beneath scapula.

7. Cleanse the area thoroughly with alcohol swab, using friction.

   NOTE: Pathogens present on skin can be forced into the tissue by the needle.

8. Hold skin taut while inserting needle at 15° angle with the bevel of the needle upward. The needle should be visible through the epidermis.

   NOTE: It is easy to insert too deeply.

9. Inject the fluid producing a small bleb just under the skin.

   NOTE: The bleb indicates correct insertion of fluid.

10. Withdraw needle quickly and wipe site very lightly.

    NOTE: Do not massage because the medication may disperse into the tissue or out through the needle insertion site.

11. Encircle the area with a marker.

    NOTE: This helps identify the site for checking redness and induration (the indicators of an allergic response).

12. Dispose of needle in designated area.

13. Immediately record all medications given.

SUMMARY AND CONCLUSION

1. Discuss interaction items.

2. Review steps of procedure.

LESSON PLAN: 7

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

INTERACTION ITEMS:

1. What are intradermal injections used for?
2. Why is a circle placed around the insertion site?
3. Where are intradermal injections commonly given?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Have a station set up in the clinical laboratory at which the following activity is performed:
    a. Intrademal administration - Have students draw 0.1 cc normal saline for injection and successfully inject another student intradermally.

LESSON PLAN: 7

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

EVALUATION ITEMS

NAME OF STUDENT: ____________________

PREPARATION AND ADMINISTRATION OF INTRADERMAL INJECTIONS

DID THE STUDENT	Yes	No
1. Check the medication card against physician's order.		
2. Wash hands.		
3. Prepare the tuberculin syringe with a small amount of liquid (0.1 - 0.2 ml).		
4. Identify self and purpose for approaching patient.		
5. Identify patient by checking wristband.		
6. Locate site of choice.		
7. Cleanse the area thoroughly with alcohol swab, using friction.		
8. Hold skin taut while inserting needle at 15° angle with the bevel of the needle upward. The needle should be visible through the epidermis.		
9. Inject the fluid producing a small bleb just under the skin.		
10. Withdraw needle quickly and wipe site very lightly.		
11. Encircle the area with a marker.		
12. Dispose of needle in designated area.		

DID THE STUDENT	Yes	No
13. Immediately record all medications given.		

The student has satisfactorily completed the procedure "Preparation and Administration of Intradermal Injections" according to the steps outlined.

Instructor's Signature
(Verifying Satisfactory Completion)

(Date)

LESSON PLAN: 8

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

SCOPE OF UNIT:

This unit provides an overview of the responsibilities of the RN in medication administration. Drugs are reviewed by characteristics of drug classes. The systems of measurement and methods of conversion between systems are described. Routes of administration and nursing implications are listed. The growing problem of drug abuse is briefly covered.

INFORMATION TOPIC: X OR DEMONSTRATION:

SYSTEMS OF MEASUREMENT, CONVERSIONS, AND CALCULATIONS
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Identify the basic units for weight and volume measurement in the metric and the apothecaries system.
2. Convert units of measurement within the metric system at 100 percent accuracy.
3. Convert units of weight between measurement systems at 100 percent accuracy.
4. Convert units of volume between measurement systems at 100 percent accuracy.
5. Calculate fractional dosages at 100 percent accuracy.
6. Write the conversion for gr to mg, Gm to gr, fluid ounces to ml, and teaspoons to ml.
7. Calculate the intravenous infusion rate for ml per hour and drops per minute.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Metric Table of Units
2. HO 2: Equivalent Measures

3. AS 1: Pretest
4. AS 2: Practice for Conversion Between Systems
5. AS 3: Practice for Calculation of Fractional Dosage

INFORMATIONAL ASSIGNMENT: (Student)

Kozier, B. and G. Erb. Fundamentals of Nursing: Concepts and Procedures. 2nd ed. Menlo Park, CA: Addison-Wesley Publishing Co., 1983. pp. 947-951.

REFERENCES: (Instructor's Additional Information)

Fitch, G., et al. Basic Arithmetic and Drug Therapy, 4th ed. New York: Macmillan Publishing Company, 1977.

Hegstad, L. and W. Hayek. Essential Drug Dosage Calculations. Englewood Cliffs, NJ: Prentice-Hall, Inc., 1983.

INTRODUCTION:

One of the rights of clients is to receive drugs in the right dose. Sometimes a drug is dispensed from the pharmacy in grams when the order calls for milligrams or in grains when the order calls for milligrams. It is the nurse's responsibility to convert units of measure and calculate dosages accurately so that the client receives the right dose. This lesson will review systems of measure and practice conversion within systems and between systems. Practice will be provided for calculating dosage from stock solutions.

LESSON PLAN: 8
COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

INFORMATION TOPIC: IV-8

OUTLINE: (Key Points)

I. Systems of Measurement

A. Metric system (HO 1)

1. Organized into units of ten; basic units divided or multiplied by ten to form secondary units

2. Consider only weight and volume when converting in drug problems.

3. Basic units are the meter, liter, and gram

4. Secondary units are the milliliter and milligram

B. Apothecaries system

1. Is the traditional unit of measure in the United States

2. Volume measurement in the apothecaries system

a. Tablespoon (Tbs)

b. Fluid ounce (℥)

c. Pint (pt)

d. Gallon (G)

3. Weight

a. Grain (gr)

b. Ounce (oz)

c. Pound (lb)

II. Convert Units of Weight Between Measurement Systems (HO 2)

A. Pharmacy may dispense medication in one system while the order is written in another system.

B. Nurse must have commonly used approximate equivalents memorized.

C. One of the common weight conversions that a nurse uses is grains to milligrams.

D. The equivalent measures chart shows the conversion as 1 grain = 60 mg. If the nurse had an order for 300 mg of aspirin and had a bottle of 5 grain aspirin tablets, she would know that 1 grain is to 5 grains as 60 mg is to X mg, or

$$1/5 = 60/x$$
$$X = 5(60)$$
$$X = 300 \text{ mg}$$

one 5 grain tablet is the same as a 300 mg tablet.

III. Convert Units of Volume Between Measurement Systems (HO 2)

A. Physicians may write an order for an elixer to be given in teaspoons. Pharmacy may dispense the elixer in ml.

B. The nurse must have memorized the conversion between units of volume.

C. On the equivalent measures chart, one teaspoon equals 5 ml.

D. If a physician ordered Pennicillin 125 mg (1 tsp) and the elixer was dispensed as 125 mg per 5 ml, the nurse would know to give 5 ml of elixer.

IV. Calculation of fractional dosages (AS 3)

A. Sometimes medications come from pharmacy in a large quantity of stock supply.

B. The physician orders a dosage which is a fraction of the stock supply.

C. The nurse calculates the dosage using the following equation:

$$\frac{\text{amount of drug desired}}{\text{amount of drug in solution}} \quad X \quad \text{quantity} = \text{amount to be given}$$

Example: 100,000 units of drug are ordered.

The label on the bottle reads 200,000 units per 5 ml.

$$\frac{\text{100,000 (amount desired)}}{\text{200,000 (amount in solution)}} \quad X \;\; \text{5 ml (quantity)} = \tfrac{1}{2} \times 5 =$$

2.5 ml of solution to be given

D. Reconstitution of drugs in powder form

1. Sometimes a nurse must reconstitute a dry form of a drug and determine the dosage to give.

2. When reconstituted, the volume may be more than the volume added because the powder adds volume. The amount of increase varies from drug to drug.

3. When reconstituted, the nurse must label the vial with the following information:

   a. Date mixed

   b. Date and time to discard

   c. Dosage in a specific volume (i.e., 100 mg/cc)

   d. Initials of the nurse who prepared the drug

4. Directions for reconstitution of the drug are written on the side of the bottle or on the package insert.

   a. Directions may be simple:

      Order: Capastat Sulfate 1.0 Gm IM qd
      Available: Capastat Sulfate 1 GM vial

      Dissolve in 2 ml of .9% NaCl injection.

      With these instructions 2 ml of NS is injected and the entire amount is withdrawn to equal 1 Gm of Capastat Sulfate.

   b. Directions may have multiple instructions:

      Order: Loridine 500 mg IM q 8 hours.
      Available: Loridine 500 mg per vial.

      Add 2 ml of solvent to obtain a concentration of 200 mg/ml; add 5 ml to obtain a concentration of 100 mg/ml.

      Add 2 ml and withdraw total amount.

   c. Directions may list only the amount of solvent and not the expected concentration:

      Order: Keflin 500 mg IM q 6 hours
      Available: Keflen vial containing 1 Gm;

      The directions state to add 4 ml of sterile water for injection.

      Add 4 ml. Draw up entire contents of vial and return one half of volume to vial and administer remaining one-half volume.

   d. Directions may list various volumes of solvent which should be used to derive a specific dosage:

Available: A 5 ml vial containing 1 Gm of Capastat Sulfate

Dissolve with 0.9% sodium chloride injection according to the dilution table.

Diluent Added to 1 Gm Vial	Approximate Concentration per 1 ml.
2.15 ml	350 mg
2.63 ml	300 mg
3.3 ml	250 mg
4.3 ml	200 mg

5. In choosing the amount of solvent to add to a powder, remember that the total volume of the injection should fall between 0.5 cc and 2.5 cc.

V. Doses for Infants and Children

A. Because of smaller body size, doses for children are smaller and are not standardized.

B. The nurse must calculate a fractional dose in keeping with the smaller body size.

C. Clark's rule is frequently used because it is based on weight rather than age.

$$\text{Child's dose} = \frac{\text{weight of child in pounds}}{150} \times \text{adult dose}$$

D. Practice using Clark's rule is provided during pediatric clinical experience.

VI. Calculation of Intravenous Infusion Flow Rates

A. It is the nurse's responsibility to maintain a constant rate of flow.

B. Too rapid infusion rates result in overloading the intravascular compartment causing serious cardiac and pulmonary complications.

C. Too slow infusion rates result in inefficient fluid and electrolyte replacement.

D. Hourly rates can be calculated by dividing the total infusion volume by the total time in hours. If 3000 ml are to be infused in 24 hours, the number of milliliters per hours is:

$$\frac{3000 \text{ (total infusion volume)}}{24 \text{ (total time of infusion)}} = 125 \text{ ml/hour}$$

E. It is wise to tape the bottle marking the exact time and/or amount to be infused.

F. The drops per minute must be regulated to ensure that the prescribed amounts of solution will infuse.

G. Equipment from different companies varies in the amount of drops delivered per cc.

H. The formula for calculation of drops infused per minute:

$$\frac{\text{total volume infused}}{\text{total time of infusion in minutes}} \quad \times \quad \text{drop factor (drops/ml)}$$

If 125 ml are to be infused over one hour using tubing that delivers 15 drops per ml, the formula is:

$$\frac{125 \text{ ml}}{60 \text{ min}} \quad \times \quad 15 \text{ drops} \quad = \quad \frac{1875}{60} = \quad 31 \text{ drops per minute}$$

VII. Summary and Conclusion

A. Systems of measurement

B. Convert units of weight between measurement systems

C. Convert units of volume between measurement systems

D. Calculation of fractional dosages

E. Doses for infants and children

F. Calculation of intravenous infusion flow rates

LESSON PLAN: 8

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

INTERACTION ITEMS:

1. Why must a nurse know how to convert between the metric and apothecaries systems?
2. What are the basic units and secondary units for weight and volume in the metric system?
3. What is a fractional dosage?
4. Why do the drops per cc vary in different problems?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Assignment Sheet 1: Pretest - students use this to refresh their basic math skills and discover areas of weakness
2. Assignment Sheet 2: Conversion practice to supplement class lecture
3. Assignment Sheet 3: Calculation of fractional dosage to supplement classroom learning

LESSON PLAN: 8

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

EVALUATION ITEMS:

____ 1. The basic units for weight and volume measurements in the metric system (in proper order) are:

a. Ounce and tablespoon
b. Grain and liter
c. Grain and milliliter
d. Gram and liter

2. Change 2 Gm to mg: ________

3. Change 125 ml to liters: ________

4. Change 1.5 Gm to mg: ________

5. Convert ½ gr to mg: ________

6. Convert 3 Gm to grains: ________

7. Convert 3 fluid ounces to ml: ________

8. Convert 2 teaspoons to ml: ________

9. Convert 4000 ml to qt: ________

____ 10. The doctor ordered cloxacillin 75 mg. The label on the 80 ml bottle reads cloxacillin 125 mg per 5 ml. How much of the solution should be given?

a. 2 ml
b. 2.5 ml
c. 8.3 ml
d. 3 ml
e. Correct answer not given

____ 11. The doctor ordered cyancocobalamin 15 mg. The label on the 10 ml. vial reads cyancocobalamin 60 mg per ml. How much of the solution should be given?

a. 60 ml
b. 0.5 ml
c. 0.25 ml
d. 4 ml
e. None of the above

______ 12. The doctor ordered deslanoside 300 mg. The label on the 4 cc ampule reads deslanoside 200 mg per ml. How much solution should be given?

a. 1.5 cc
b. 3 cc
c. 0.5 cc
d. 0.25 cc
e. None of the above

13. Order: Kefzol (cefazolin sodium) 500 mg. IM q 12^0

Available: Vials containing Kefzol 250 mg and 1 Gm. Add 2 ml diluent to the 250 mg vial to obtain an approximate concentration of 125 mg/ml Add 2.5 ml of diluent to the 1 Gm vial to obtain an approximate concentration of 330 mg/ml

a. What strength vial of Kefzol should you use?

b. How many ml of diluent should you add to the vial?

c. How many ml should you administer to equal the prescribed dose?

14. a. How many milligrams in a grain?

b. How many milliliters in a fluid ounce?

15. Mrs. Doe is restricted to 1000 cc of IV fluid per 24 hours.

a. How many cc's will she receive per hour?

b. How many drops per minute will this be if you are using tubing that delivers 60 drops per cc?

LESSON PLAN: 8

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

ANSWERS TO EVALUATION ITEMS

1. d
2. 2000 mg
3. .125 liters
4. 1500 mg
5. 30 mg
6. 45 grains
7. 90 ml
8. 10 ml
9. 4 qts
10. d
11. c
12. a

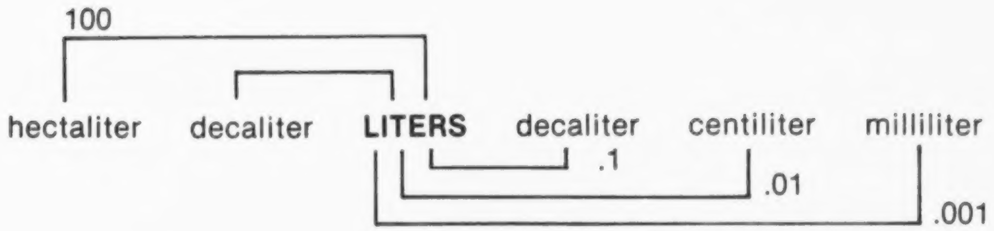
13. a. 1 Gm
    b. 2.5 ml
    c. 1.5 ml

14. a. 60 mg
    b. 30 ml

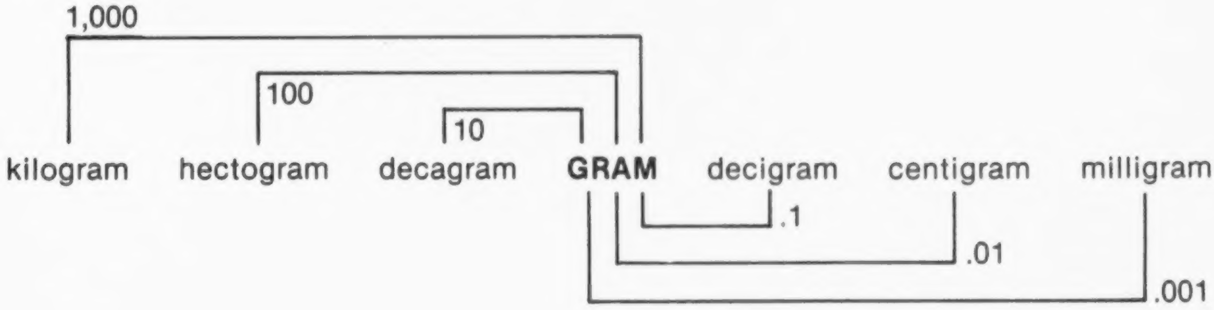
15. a. 41
    b. 60 drops/min

Metric Table of Units

Volume - Basic Unit is Liter


100
hectaliter
decaliter
LITERS
decaliter
centiliter
milliliter
.1
.01
.001

Weight - Basic Unit is Gram


1,000
100
10
kilogram
hectogram
decagram
GRAM
decigram
centigram
milligram
.1
.01
.001

1. If the decimal point is moved to the right, the value is multiplied by 10. 0.1 × 10 = 1.0

To convert from a larger measure to a smaller measure, multiply.

> To convert 5 l to ml, multiply .5 l by 1000 since ml is three places to the right of l. .5 l × 1000 = 500 ml
>
> To convert 2 Gm to mg, multiply 2 Gm by 1000 since mg is three places to the right of Gm. 2 Gm × 1000 = 2000 mg

2. If the decimal point is moved to the left, the value is divided by 10. 1.0 ÷ 10 = 0.1

To convert from smaller measure to a larger measure, divide.

> To convert 100 mg to Gm, divide by 1000 since Gm is three places to the left of mg. 100 mg ÷ 1000 = 0.1 Gm
>
> To convert 2500 ml to liters, divide by 1000 since liters are three places to the left of ml. 2500 ml ÷ 1000 = 2.5 liters

HO 2

Equivalent Measures

Metric		Apothecaries/Household
1 ml	=	15 minims - 15 drops
5 ml	=	1 tsp
15 ml	=	1 Tbs
30 ml	=	1 fluid ounce
500 ml	=	1 pint
1000 ml	=	1 quart
1 mg	=	1/60 grain
60 mg	=	1 grain
1 Gm	=	15 grains
1000 Gm (1 Kg)	=	2.2 lb

PRETEST

1. Multiply 432.5 x 12
   - a. 518.0
   - b. 5190.0
   - c. 41900.0
   - d. 5290.0
   - e. None of the above

2. Change 20% to a fraction
   - a. 1/2
   - b. 1/10
   - c. 1/50
   - d. 1/5
   - e. None of the above

3. Divide 5.95 by 8.5
   - a. 0.7
   - b. 7
   - c. 0.007
   - d. 0.07
   - e. None of the above

4. Multiply 0.5 x 1,000
   - a. 200
   - b. 5000
   - c. 50
   - d. 5
   - e. None of the above

5. Change 3/4 to percent
   - a. 67%
   - b. 60%
   - c. 75%
   - d. .8
   - e. None of the above

6. Multiply 2 1/9 x 3 1/2

   a. 6 1/2
   b. 5 11/8
   c. 7 1/9
   d. 7 7/18
   e. None of the above

7. Divide 1/2 by 1/6

   a. 1/12
   b. 2
   c. 3
   d. 6
   e. None of the above

8. Multiply .009 x 0.03

   a. 0.00027
   b. 27
   c. .0012
   d 2.7000
   e. None of the above

9. Divide 8, 358 by 0.04

   a. 2089.5
   b. 2.08950
   c. 20895
   d. 21895
   e. None of the above

10. Divide 3.90 by 0.3

   a. 130
   b. .013
   c. 1.3
   d. 12
   e. None of the above

11. At the drug store you were sold 50 tablets of Indocin 25 mg for $16.00. How much does one tablet of Indocin cost?

   a. 31¢
   b. 64¢
   c. .04¢
   d. 50¢
   e. None of the above

12. How many milliliters would you give to administer Keflin 250 mg when there is 500 mg in one milliliter?

    a. 2 ml
    b. 1 1/2 ml
    c. .5 ml
    d. .2 ml
    e. None of the above

13. Which fraction is the largest?

    a. 1/2
    b. 1/3
    c. 1/4
    d. 1/5
    e. 1/6

14. The client's bill was $2,100 and the insurance company paid 80%. What amount must the client pay?

    a. $1680
    b. $410
    c. $1344
    d. $2100
    e. None of the above

15. The label on the bottle reads Benadryl 25 mg. The prescription reads 75 mg of Benadryl every 4 hours as needed. How many tablets should you take?

    a. 1/3
    b. 2
    c. 3
    d. 4
    e. None of the above

AS 2

PRACTICE FOR CONVERSION BETWEEN SYSTEMS

1. 0.5 liter = ______ml
2. 30 mg = ______Gm
3. 0.25 liters = ______ml
4. 100 mg = ______Gm
5. 30 grains = ______Gm
6. 500 mg = ______gr
7. 80 lb = ______Kg
8. 2 Tbs = ______ml
9. 60 minims = ______ml
10. 5 grains = ______Gm

PRACTICE FOR CALCULATION OF FRACTIONAL DOSAGE

1. The label on the 40 ml stock bottle reads penicillin V 125 mg per 5 ml and the doctor's order reads penicillin V 250 mg. How much should be given?

2. Penicillin G potassium 20,000 units was ordered, and the label on the 60 ml bottle reads penicillin G potassium 100,000 units per 5 ml. How much should be given?

3. The label on the 30 ml stock bottle reads Demerol 100 mg per 1 ml and the doctor's order reads "give Demerol 80 mg." How much should be given?

4. The doctor ordered levarterenol 1 mg. The label on the ampule reads levarterenol 2 mg per cc. How much solution from the ampule should be given?

5. The doctor ordered Atropine 0.6 mg IM preoperatively. The label on the 1 cc ampule reads 0.4 mg per cc. How many ampules are needed? What is the amount of solution that will be given?

LESSON PLAN: 8

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

ANSWERS TO ASSIGNMENT SHEETS

AS 1

1. b
2. d
3. a
4. e
5. c
6. d
7. c
8. a
9. e
10. e
11. e
12. c
13. a
14. c
15. c

AS 2

1. 500 ml
2. .03 Gm
3. 250 ml
4. .1 Gm
5. 2 Gm
6. 7.5 gr
7. 36.5 Kg
8. 60 ml
9. 4 ml
10. 0.3 Gm

AS 3

1. 10 ml
2. 1 ml
3. .8 ml
4. 0.5 ml
5. 2, 1½ cc

LESSON PLAN: 9

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

SCOPE OF UNIT:

This unit provides an overview of the responsibilities of the RN in medication administration. Drugs are reviewed by characteristics of drug classes. The systems of measurement and methods of conversion between systems are described. Routes of administration and nursing implications are listed. The growing problem of drug abuse is briefly covered.

INFORMATION TOPIC: X OR DEMONSTRATION:

DRUG ABUSE
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Identify myths/realities of pain management with narcotics.
2. Define terms associated with drug misuse.
3. List the nursing responsibilities associated with problems of drug dependence.
4. Describe the characteristics of the chemically impaired nurse.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

INFORMATIONAL ASSIGNMENT: (Student)

Kozier, B. and G. Erb. Fundamentals of Nursing: Concepts and Procedures. 2nd ed. Menlo Park, CA.: Addison-Wesley Publishing Co., 1983. pp. 942-943.

REFERENCES: (Instructor's Additional Information)

Malseed, R. Pharmacology: Drug Therapy and Nursing Considerations. Philadelphia: J. B. Lippincott Company, 1982.

INTRODUCTION:

Drug misuse has reached epidemic proportions in the past decade despite legislative and educational interventions. Misuse involves both prescription and over-the-counter drugs. Misuse can lead to problems such as GI bleeding, kidney damage or liver damage. Because nurses work daily with the drugs most abused and with highly stressed people seeking pharmaceutical solutions to problems, it is important that they understand their role in the prevention of drug misuse.

LESSON PLAN: 9

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

INFORMATION TOPIC: IV-9

OUTLINE: (Key Points)

I. Pain Management with Narcotics: Myths and Realities

   A. Narcotics are an important adjunct in pain control.

   B. Withholding narcotics because of fear of drug dependence is not good nursing care.

   C. Addiction doesn't usually occur when drugs are used a short time (one to two weeks).

   D. Addiction doesn't occur when drug being used for pain relief instead of euphoria.

II. Terms Associated With Drug Misuse

   A. Misuse - use of any drug in a manner that deviates from generally accepted medicosociological norm

   B. Habituation - pattern of repeated drug usage although actual physical need is minimal

   C. Dependence

      1. Psychological - a compulsive need to experience a pleasurable drug reaction; absence of the drug impairs the ability to function continually in a socially acceptable manner

      2. Physical - regular drug use necessary to avoid precipitation of withdrawal reactions that can be severe

   D. Addiction - quantitative term usually applied to severe habituation or physical dependence

III. Nursing Responsibilities in Problem of Drug Misuse

   A. Recognition of precipitating factors for misuse

      1. Indiscriminate prescribing

      2. Inadequate monitoring of psychoactive drugs

      3. Emotional instability

4. Environments that promote or permit

B. Recognition and reporting of early signs of drug dependence

1. Need for ever increasing doses
2. Seeking of euphoria rather than pain relief

C. Identification of withdrawal symptoms

D. Health teaching on proper use of drugs

IV. Characteristics of Chemically-impaired Colleagues

A. Nurses have dependence rate five times greater than general population

1. Work in environment that promotes pharmaceutical coping
2. Availability of drugs
3. Nature of profession emphasizes trying to be all things to all people, creates excessive stress
4. Can happen to any nurse, no specific personality type

B. Suspicions should be raised with the following events:

1. Narcotic counts are inaccurate
2. Patients report no relief from pain medications
3. Patient states he/she hasn't received medication when it is documented as being given
4. Nurses have consistently dilated pupils and wide mood swings
5. Nurse frequently changes job; may be working at job below level of competence

C. Chemical abuse is curable disease

1. It is important to do something since clients can have their lives endangered.
2. Document behavior that is suspicious to see if there is a pattern. Don't accuse someone prematurely.
3. Report suspicions to head nurse. Involve minimal number of people in reporting.
4. Missouri Nurses Association (MONA) has a peer assistance program and can provide guidelines for reporting.

V. Summary and Conclusion

A. Pain management with narcotics: myths and realities

B. Terms associated with drug misuse

C. Nursing responsibilities in problem of drug misuse

D. Characteristics of chemically-impaired colleagues

LESSON PLAN: 9

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

INTERACTION ITEMS:

1. How can a nurse know that a patient requesting narcotic is in pain if he/she isn't grimacing?
2. How do habituation and dependence differ?
3. What kind of environment would promote drug misuse?
4. What are behaviors that may indicate drug misuse in a nurse colleague?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

LESSON PLAN: 9

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

EVALUATION ITEMS

True or False: Write "T" if the statement is true or "F" if it is false.

_____ 1. A nurse should suspect potential addiction if a client requires a narcotic every four hours 3 days after surgery.

_____ 2. Addiction doesn't usually occur when the client requires a narcotic for obvious pain relief.

_____ 3. A person who experiences relief from a placebo is an emotionally unstable personality.

_____ 4. The nurse must be aware of withdrawal behaviors associated with various central nervous system drugs.

_____ 5. Nurses who become chemically-impaired are usually slovenly and unethical.

_____ 6. Habituation is defined as regular drug use necessary to avoid severe withdrawal symptoms.

LESSON PLAN: 9

COURSE TITLE: LPN/ADN BRIDGE COURSE

UNIT IV MEDICATION ADMINISTRATION

ANSWERS TO EVALUATION ITEMS

1. F
2. T
3. F
4. T
5. F
6. F

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COMPETENCY PROFILE FOR LPN/ADN BRIDGE COURSE

Student Final Record

Student Name:____
Last First Middle

Permanent Address:____

Social Security Number:____

Instructor's Signature:____

Directions: This profile provides a permanent record for student, instructor, and/or industry representative. The competencies listed below **correspond** directly to the lessons presented in this curriculum guide. Compile your evaluation of the student (trainee) by transferring the **appropriate** "yes/no" rating from the various demonstration lessons, or by indicating "yes/no" if the student (trainee) has mastered objectives **contained** in information lessons.

YES NO

ROLE OF THE ASSOCIATE DEGREE NURSE

___ ___ 1. Describe nursing philosophy as related to this school's program.
___ ___ 2. Describe nursing theory as related to this school's program.
___ ___ 3. Discuss conceptual framework and its application in the nursing curriculum.
___ ___ 4. Discuss the major roles of the ADN.
___ ___ 5. Describe the decision making process.

COMMUNICATION

___ ___ 6. Identify terms related to the communication process in the nurse-client relationship.
___ ___ 7. Describe the kinds of communication and the skills required to use them effectively.
___ ___ 8. Describe coping mechanisms and their effects on the communication process.
___ ___ 9. Describe the goals of the nurse-client interview and the importance of the process recording.
___ ___ 10. Discuss the documentation-recording process and the content required for the charting of nurse's notes.
___ ___ 11. Discuss the documentation-reporting process and methods utilized in change of shift reports.
___ ___ 12. Describe the elements of the client teaching/learning process.

NURSING PROCESS

___ ___ 13. Describe the elements and phases of the nursing process.
___ ___ 14. Discuss the methods of data collection and organization employed in nursing assessment.
___ ___ 15. Describe the nursing history, including major areas and the types of questions that are appropriate to each area.
___ ___ 16. Discuss physical assessment techniques.
___ ___ 17. Discuss the nursing diagnosis.
___ ___ 18. Describe the planning phase including principles used to determine client goals and associated nursing orders.
___ ___ 19. Describe the implementation phase including areas of nursing intervention.
___ ___ 20. Discuss the evaluation phase and the impact on the nursing care plan.
___ ___ 21. Write a nursing care plan.

MEDICATION ADMINISTRATION

___ ___ 22. Discuss the legal implications and responsibilities of the RN in medication administration.
___ ___ 23. Identify actions, uses and common side effects for various classes of drugs.
___ ___ 24. Identify general principles of medication administration.
___ ___ 25. Prepare and administer oral medications.
___ ___ 26. Prepare and administer intramuscular injections.
___ ___ 27. Prepare and administer subcutaneous injections.
___ ___ 28. Prepare and administer intradermal injections.
___ ___ 29. Use calculations to convert between measurement systems, determine fractional doses, and establish IV flow rates.
___ ___ 30. Discuss nursing responsibilities associated with problems of drug dependence.

Competency Certificate

This is to Certify that:

____

Achieved the Major Job Competencies
as Acknowledged for the

LPN/ADN Bridge Course

And is Therefore Recognized

This ________ *Day of* ____________________________ *, 19* _____

____
Instructor

____
Administrator